County of Los Angeles
HIV Care and Treatment Service Utilization

2013 Year End Report

May 2015

COUNTY OF LOS ANGELES
Public Health
Division of HIV and STD Programs

Los Angeles County Department of Public Health

Cynthia A. Harding, M.P.H
Interim Director

Jeffrey D. Gunzenhauser, MD, M.P.H
Interim Health Officer

Division of HIV and STD Programs

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Director

Michael Green, Ph.D., M.H.S.A.
Chief, Office of Planning

Carlos Vega-Matos, M.P.A.
Chief, Care Services

Dave Young
Chief, Financial Services

Mike Janson, M.P.H.
Chief, Program Evaluation and Data Management

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Authors and Contributors

Juhua Wu, M.A., Care Grants and Planning Manager
Yuwen Yue, M.P.H., Research Analyst
Elizabeth Escobedo, Planning Analyst
Pamela Ogata, M.P.H., Epidemiologist
Rangell Oruga, M.P.H., Research Analyst
Khrystyne Fong, Fiscal Grants Manager

Contact Information

Division of HIV and STD Programs
600 South Commonwealth Ave., 10th Floor
Los Angeles, CA 90005
Phone (213) 351-8000
Office Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m.

A Few Words about Data

This report represents service utilization among clients receiving DHSP-funded HIV care and treatment services in Los Angeles County during FY 2013 (March 1, 2013 – February 28, 2014). Because around 90% of these services were supported by various Ryan White Program funds (Part A and Minority AIDS Initiative [MAI] from the federal Health Resources and Services Administration and Part B and ADAP enrollment from California Office of AIDS), we have referred to the clients and services as Ryan White clients and Ryan White Program (RWP) in general.

Several data sources were used to present this service utilization profile. The primary data source for this report is Casewatch, DHSP's client-level data reporting system, extracted and analyzed by the DHSP's Program Evaluation and Data Management Section.

For the first time this year, health outcomes data are presented for overall clients as well as clients who utilized each of the funded service categories. These data are a result of matching Casewatch data and HIV surveillance data from the electronic HIV/AIDS Reporting System (eHARS) for the same time period. Although the matched rate is only 96%, meaning hundreds of client records are excluded from the health outcomes data, the resulting data still offer important clues on how the clients are doing overall, even if they did not use RWP for their HIV medical care.

Service utilization for some Net County Cost (NCC) supported service categories are not tracked in Casewatch; they are collected through individual tracking systems at the funded agencies and reported to DHSP through program reports. These data are provided by DHSP Care Services Division. Data for the state AIDS Drug Assistance Program (ADAP) enrollment are obtained through Ramsell, the State-contracted pharmacy administrator for ADAP.

Financial data for each service category are presented in terms of year-end expenditures and are presented in table form by funding source, (e.g. Part A, Part B, Other) and final combined total expenditures. RWP MAI, NCC, and other expenditures are included in "Other" with footnotes indicating the funding source and year-end expenditures.

For both the utilization data and financial data, multiple time frames are included because of the varied funding cycle for each funding source. Tables 1.1 and 1.2 describe the data periods for service utilization and financial data.

Table 1.1: Service Utilization Data Periods by Funding Source

Funding Source	Data Period
HRSA - RWP Part A	March 1, 2013 – February 28, 2014
HRSA - RWP MAI	
State RWP Part B	
County NCC	July 1, 2013 – June 30, 2014

Table 1.2: DHSP Financial Data Periods by Funding Source

Funding Source	Data Period
HRSA - RWP Part A	March 1, 2013 – February 28, 2014
HRSA - RWP MAI	
State RWP Part B	April 1, 2013 – March 31, 2014
County NCC	July 1, 2013 – June 30, 2014

Chapter 1. Introduction

Background

Los Angeles County is home to an estimated 60,050 people living with HIV/AIDS. As of December 31, 2013, there are 50,550 diagnosed HIV/AIDS cases and an additional 9,500 cases are estimated to be undiagnosed, (i.e. people who are unaware of their HIV infection).

The Division of HIV and STD Programs (DHSP) coordinates the overall response to HIV/AIDS in Los Angeles County in collaboration with community-based organizations, governmental bodies, advocates and people living with HIV/AIDS. DHSP's main funding sources are the Health Resources and Services Administration (HRSA) Ryan White Program (RWP Part A and Minority AIDS Initiative [MAI]), the Centers for Disease Control and Prevention (CDC), the State of California Office of AIDS Single Allocation Model (SAM or RWP Part B), and Los Angeles County general funds. Several other funding sources support special projects or research studies. These include funding from Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH), and California HIV/AIDS Research Program (CHRP). DHSP utilizes these fiscal resources to manage over 200 contracts within a network of more than 100 community-based organizations and County departments in an effort to maximize access to quality services for people living with HIV/AIDS.

RWP Part A is the largest funding source for HIV care and treatment services. DHSP also receives RWP Part B funds from the California State Office of AIDS for HIV care and treatment services. Additionally, DHSP uses County general funds (Net County Cost or NCC) to support HIV care and treatment services. Table 1.3 describes the funding breakdown in fiscal year (FY) 2013.

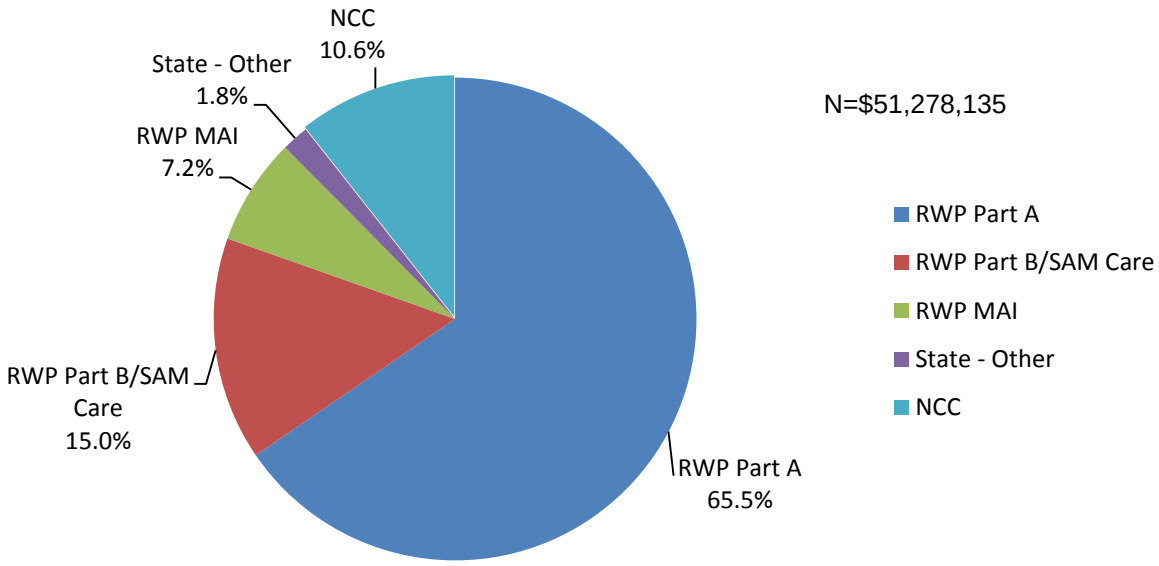
Table 1.3: DHSP HIV Care and Treatment Funding Description for FY 2013

Funding Source	Funding Term	Amount of Funding Available	Amount Used for Direct Services	Percentage of Funds Used for Direct Services
RWP Part A	3/1/2013 – 2/28/2014	$35,179,363	$30,173,519	85.8%
RWP Part B	4/1/2013 – 3/31/2014	$8,664,047	$7,814,370	90.2%
RWP MAI	3/1/2013 – 2/28/2014	$3,038,947*	$2,735,053	90.0%
State – Other	7/1/2013 – 6/30/2014	$479,392*	$479,392	100.0%
NCC	7/1/2013 – 6/30/2014	$3,916,386	$3,916,386	100.0%
	Total	**$51,278,135**	**$45,118,720**	**88.0%**

Data Source: Summary Consolidated YR 23 – Final Report 2/21/2015, DHSP Financial Services Division.
The State-Other amount includes ADAP enrollment and the Center for Substance Abuse Treatment and Prevention (CSAT/CSAP) grant.

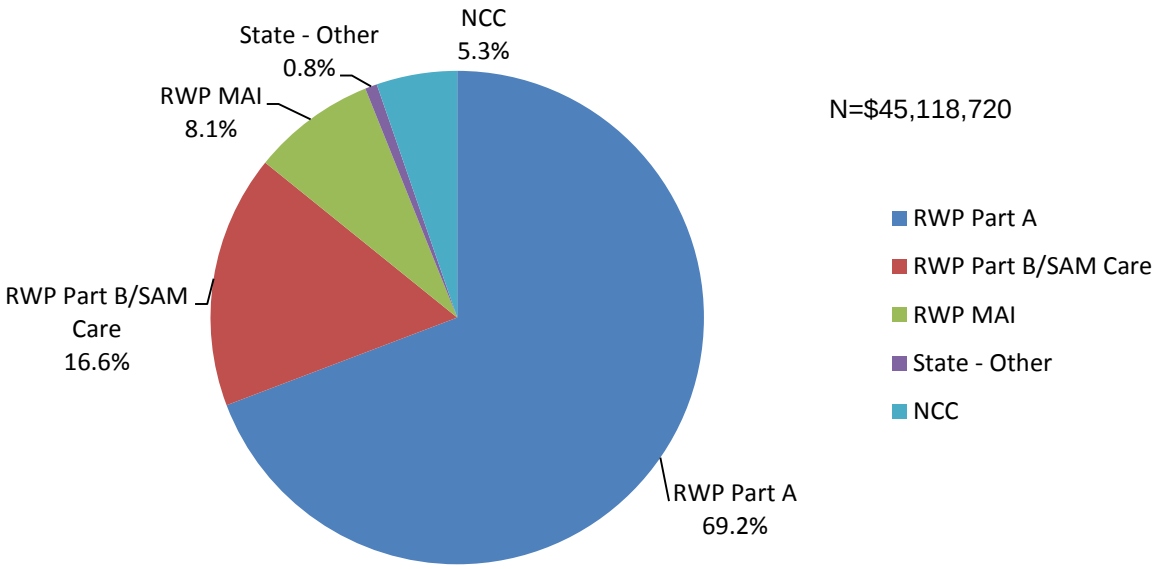
Figure 1.1 provides the percentage of DHSP funds available for HIV care and treatment services by funding source in FY 2013. *Figure 1.2* shows the percentage of DHSP direct expenditures by funding source for HIV care and treatment services in FY 2013.

Figure 1.1. Percentage of DHSP HIV Care and Treatment Funds Available, by Funding Source, FY 2013



Data Source: Summary Consolidated YR 23 – Final Report 2/21/2015, DHSP Financial Services Division

Figure 1.2. Percentage of DHSP HIV Care and Treatment Direct Expenditures by Funding Source, FY 2013



Data Source: Summary Consolidated YR 23 – Final Report 2/21/2015, DHSP Financial Services Division

This report presents an overview of the services funded and utilized during FY 2013, and descriptions of clients receiving these services.

Ryan White Program Priorities and Allocations

The RWP requires a local planning council to determine service priorities and allocations. In Los Angeles County, this task is accomplished by the Los Angeles County Commission on HIV (Commission). The Commission determines priorities and allocations for RWP Part A and State RWP Part B funding during a five-month process, primarily at the Planning, Priorities and Allocations (PP&A) Committee meetings. The PP&A decision-making process includes the following steps: 1) framework, paradigms, operating values and funding scenarios; 2) review of the HIV/AIDS epidemiologic profile; 3) presentation of needs assessment and service utilization data; 4) priority-setting; 5) resource allocations; 6) "how best to meet the need" and "other factors to be considered"; and 7) disposition of appeals, if any. The Commission approves the final recommendations made by the PP&A Committee. DHSP then develops contracts and procures services according to the recommendations of the Commission. RWP Minority AIDS Initiative allocations are determined in a separate but similar process. Throughout the year, PP&A and the Commission reviews expenditures and relevant program information to make allocation modifications as needed. The final RWP allocations for FY 2013 are outlined as Table A.1 in the Appendix. How these services are referenced as compared with service categories defined by HRSA can be found in Table A.1a in the Appendix, and also in Chapters 4 and 5.

Services Funded for FY 2013

FY 2013 was another transitional year for HIV care and treatment services as the health care system geared up for the Affordable Care Act. In the previous year, many HIV-positive patients in the Ryan White care system became eligible for Medi-Cal managed care and Healthy Way LA, the local Low Income Health Program (LIHP) run by the County of Los Angeles Department of Health Services. Because the Ryan White Program has a "payer of last resort" mandate, this means that many LIHP-eligible patients could no longer use RWP for their medical visits and prescription drug coverage for their HIV care. As shown in this report, however, many still use RWP for other types of services. Although there was a significant reduction (43%) in the number of clients utilizing RWP-funded ambulatory outpatient medical (AOM) services compared with the previous year, the overall number of clients who touched the RWP in FY 2013 remained relatively consistent, just 10% lower than the previous year.

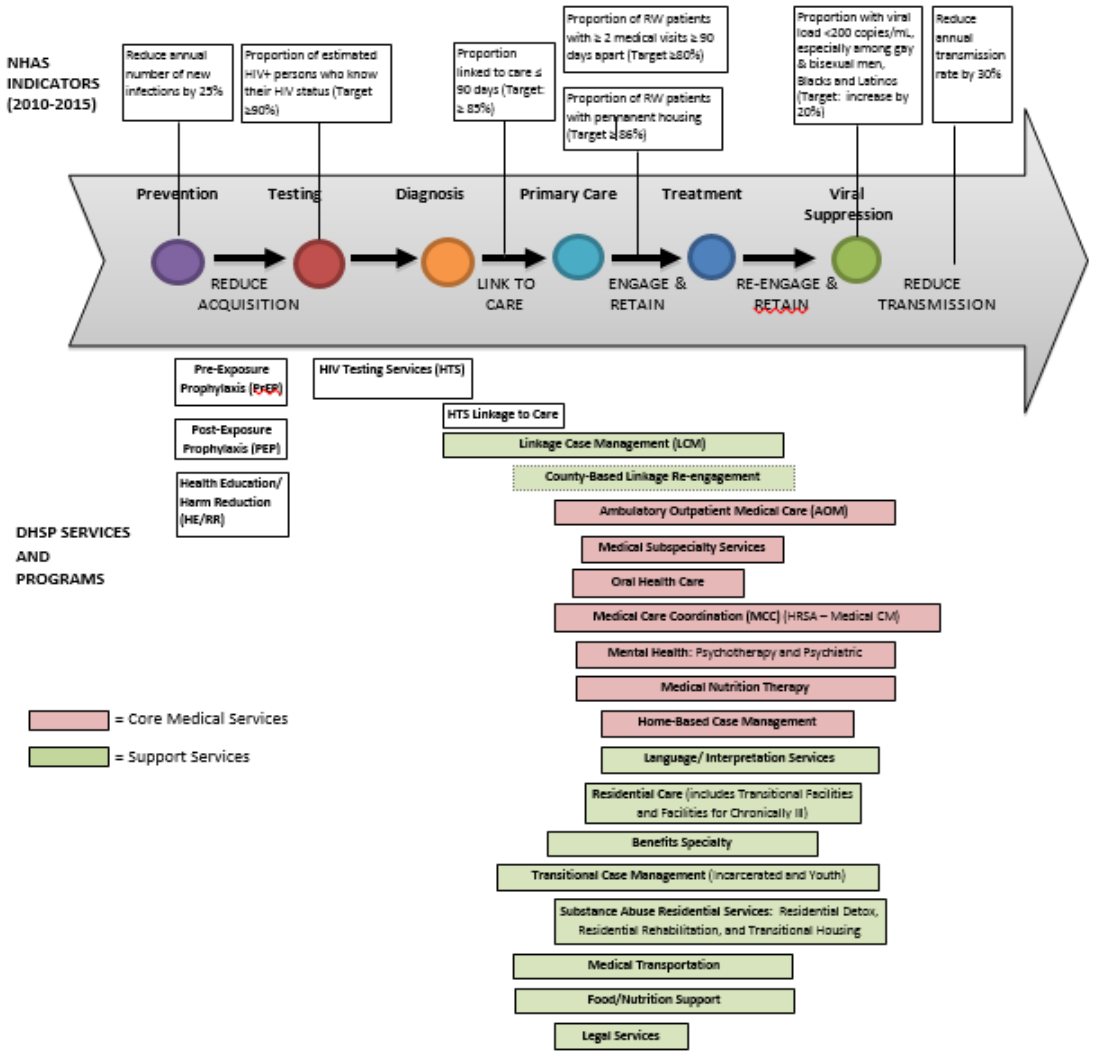
HIV care and treatment services funded by DHSP in FY 2013 were:

Core Medical Services	Support Services
1. Ambulatory Outpatient Medical Services	1. Case Management, Non-Medical
2. Medical Specialty	2. Substance Abuse, Residential
3. Oral Health Care	3. Nutrition Support
4. Mental Health, Psychiatry	4. Residential, Transitional
5. Mental Health, Psychotherapy	5. Medical Transportation
6. Medical Care Coordination	6. Language Services
7. Substance Abuse Treatment	7. Case Management, Transitional
8. ADAP Enrollment	8. Benefits Specialty
9. Case Management, Home-based	9. Legal Services
10. Medical Nutrition Therapy	

Continuum of HIV Care

The HIV service landscape has changed as the division between prevention and care dissipates. The concept of 'treatment as prevention" is catalyzing new efforts to identify individuals who are unaware of their HIV infection, as well as those who know of their infection but have never been in care or who have fallen out of care. DHSP has used the HIV care continuum to visualize how individuals transition from being diagnosed to getting initially linked into medical care, to how they get engaged in care or need to be re-engaged in care (often multiple times for certain populations), and finally to becoming retained in medical care over the long term and achieving viral suppression. *Figure 1.3* illustrates how each DHSP-funded service contributes to the HIV care continuum.

Figure 1.3. Continuum of HIV Care Arrow-mapped to NHAS and Service Category Indicators of DHSP-funded HIV Care and Treatment Services in Los Angeles County

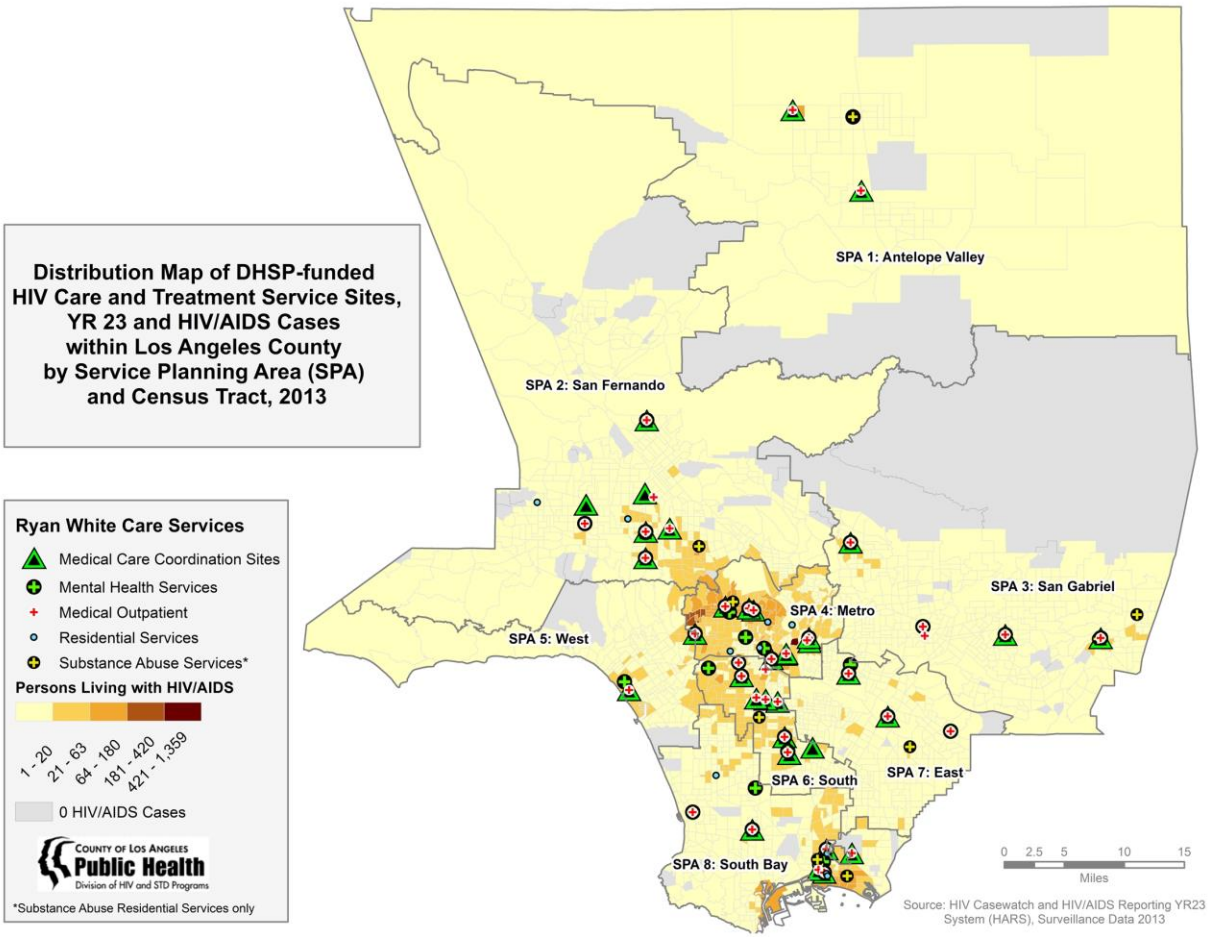


Note: This graph is adapted from the Institute of Medicine, Monitoring HIV Care in the United States: Indicators and Data Systems, 2012.

Distribution of Service Sites

Figure 1.4 illustrates the distribution of service sites and living HIV/AIDS cases by service planning area (SPA).

Figure 1.4. Distribution of DHSP-funded HIV Care and Treatment Service Sites and HIV/AIDS Cases within Los Angeles County by Service Planning Area and Census Tract, FY 2013



Chapter 2. Local HIV Epidemiologic Profile

Context of the HIV Care and Treatment Service Response

The demographic and geographic distribution of Ryan White clients supported by services funded by the Division of HIV and STD Programs (DHSP) mirror the local HIV epidemic. This chapter provides a brief summary of the local HIV epidemiologic profile and offers some context for the client profiles and service utilization data presented in this report. For more in-depth data on HIV/AIDS incidence and prevalence for 2013, refer to *Los Angeles County Department of Public Health 2013 Annual HIV Surveillance Report* published by DHSP. It can be accessed at http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf.

Distribution of HIV Cases by Demographics and Mode of Transmission

Based on the 2013 surveillance data, men represent 87.5% of people living with HIV/AIDS (PLWH) in Los Angeles (LA) County (N = 47,148). The proportion of female HIV/AIDS cases stay around 11.3%, and approximately 1.2% are transgender.

Nearly 40% of (39.3%) PLWH in LA County are Latino/a, 33.0% White, 20.2% African American, and 3.9% Asian, Pacific Islander, American Indian and Alaskan Native. Latinas and African American women comprise the majority (80.4%) of women living with HIV/AIDS in LA County.

As one of the oldest HIV epicenters, LA County tends to have older PLWH. The majority of PLWH (61.5%) are between 40 and 59 years old. Less than 1% of PLWH are 19 years and younger while 12.5% are 60 years and older.

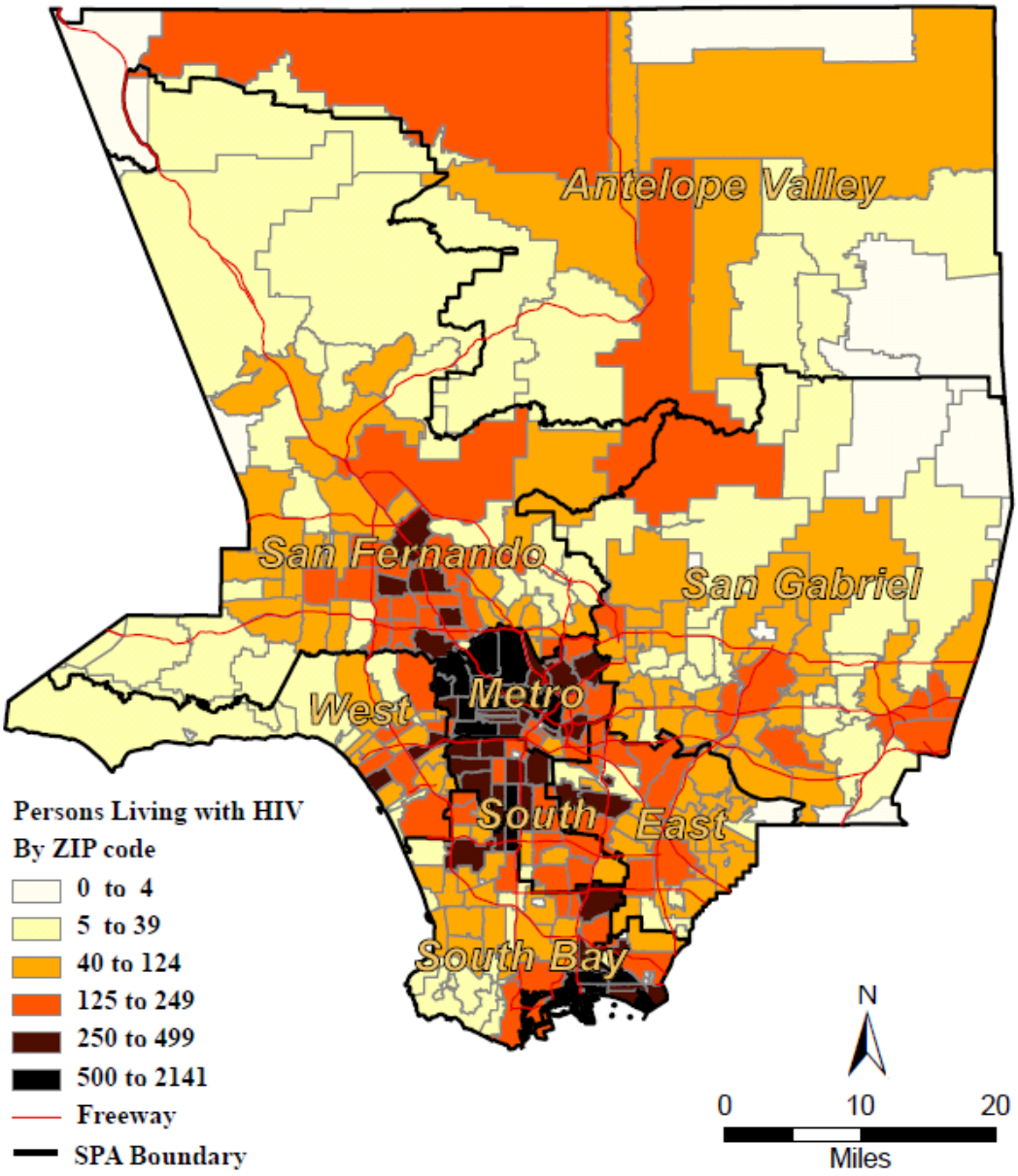
Male-to-male sexual (MSM) contact remains the primary mode of exposure for people living with HIV/AIDS in this County (83.4%, including 6.2% who injects drugs and are MSM). In addition, MSM behavior is also associated with the largest number of HIV/AIDS diagnoses for every racial and ethnic group. The numbers and proportions of HIV/AIDS cases associated with injection drug use (IDU) and perinatal transmission remain relatively low and stable.

A detailed table of living HIV cases by age, gender, race/ethnicity and exposure, extracted from the *2013 Annual HIV Surveillance Report* is included the Appendix (*Table A.2*).

Geographic Distribution of HIV Cases

Figure 2.1 illustrates the distribution of people living with HIV/AIDS across the County based on resident zip code at the time of diagnosis. Overall, Metro, South Bay, and South have the highest density of PLWH in a concentrated geographic region.

Figure 2.1. People Living with a Diagnosis of HIV Infection as of December 31, 2013, by Zip Code and Service Planning Area in Los Angeles County (N = 47,148)



Data Source: Division of HIV and STD Programs - Los Angeles County Department of Public Health. *2013 Annual HIV Surveillance Report*; 2014:12. Data are provisional due to reporting delay. Zip code information is based on the residence at the time of diagnosis or the most recently reported residence information.

Chapter 3. Client Summary

In FY 2013, 18,134 unduplicated clients receiving DHSP-funded HIV care and treatment services were reported in Casewatch, representing approximately 35.9% of the number of people diagnosed with HIV/AIDS in Los Angeles County.

During the same year, 1,864 new clients were enrolled in the DHSP-funded system of HIV care. A detailed demographic profile of the overall clients and clients who accessed DHSP-funded medical care is presented in Appendix A.

The following tables and graphs present more in-depth demographic characteristics of clients served in FY 2013, along with their distribution by Service Planning Area (SPA). Some analyses focused on populations with special needs are also included, as are client health outcomes.

Distribution of Clients by Gender, Race/Ethnicity, Age, and HIV Status

In FY 2013, 86.6% of all DHSP-funded RWP clients were male, 11.7% were female, and 1.7% were transgender. As a percentage, Latino/as accounted for 49.7% of clients, Whites represented 24.1%, African Americans 22.0%, and Asian/Pacific Islanders 3.7%.

Figure 3.1. Gender Distribution of All RWP Clients, FY 2013 (N=18,134)

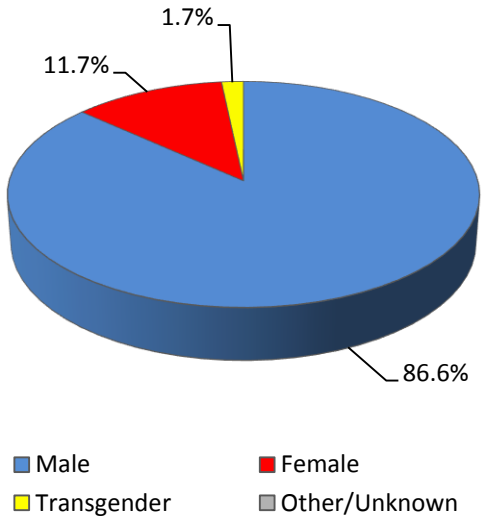
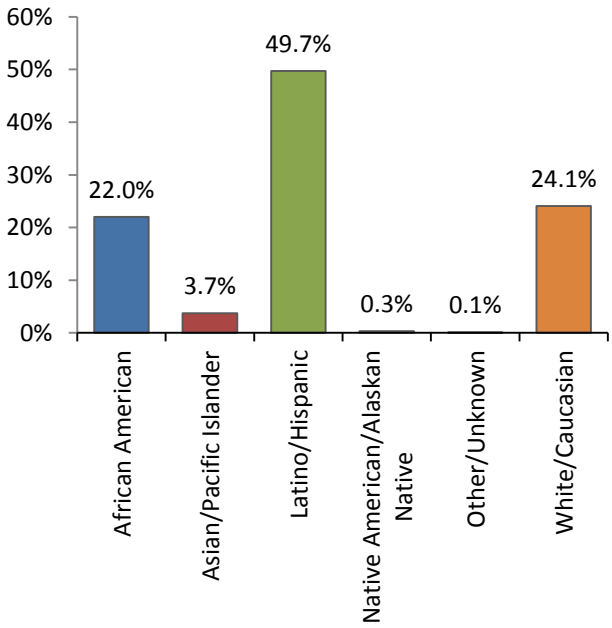


Figure 3.2. Race/Ethnicity of All RWP Clients, FY 2013 (N=18,134)

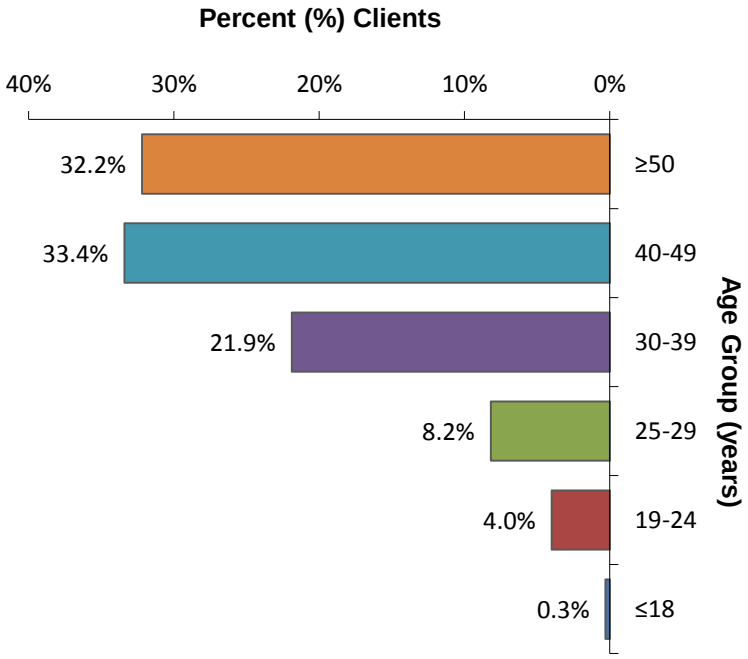


Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Figure 3.3. Age Group Distribution of All RWP Clients, FY 2013 (N=18,134)

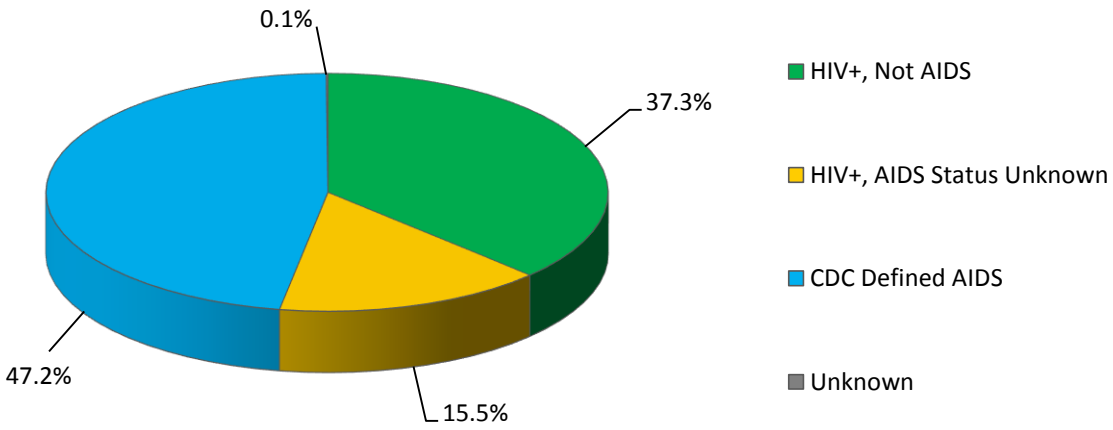
The age distribution of all clients closely mirrors that of the local HIV epidemic. The largest age group was for clients between ages 40-49 (33.4%), followed closely by 32.2% of clients 50 years and older, and 21.9% between 30-39 years old. Approximately 12.2% of young people, ages 19-29 received local RWP services in FY 2013.

Data Source: Casewatch FY 2013 (March 2013 - February 2014)



Almost half (47.2%) of RWP clients served during FY 2013 had CDC-defined AIDS, while nearly 37.3% were HIV-positive, but did not have AIDS, and 15.5% had HIV but an unknown AIDS diagnosis.

Figure 3.4 HIV/AIDS Status of All RWP Clients, FY 2013 (N=18,134)



Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Distribution of Clients by Poverty Level and Medical Insurance Status

The RWP supports the great majority of all DHSP-funded HIV care and treatment services. Targeted to serve vulnerable and underserved persons living with HIV and AIDS (PLWHA), the RWP services engage a high proportion of clients who have no medical insurance and who live below the federal poverty level (FPL).

In the new health care environment involving the implementation of the Affordable Care Act, many clients gained access to public insurance coverage through Medi-Cal expansion and County coverage initiatives.

Figure 3.5. Primary Medical Insurance Status of All RWP Clients, FY 2013

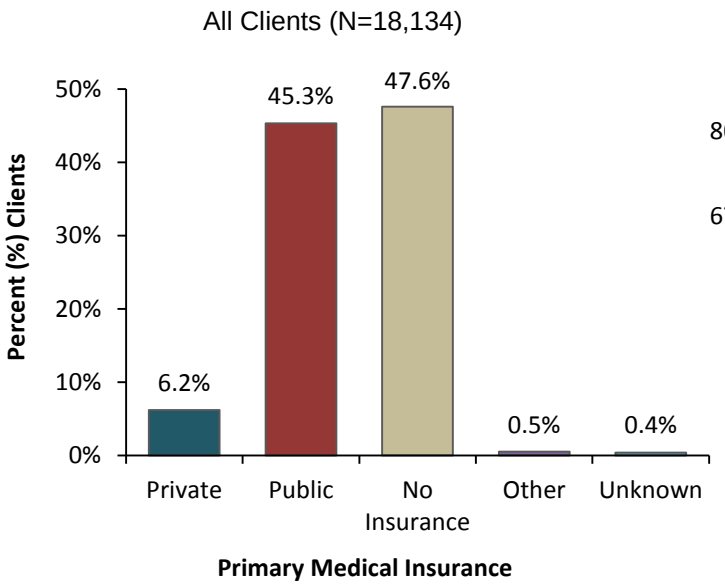
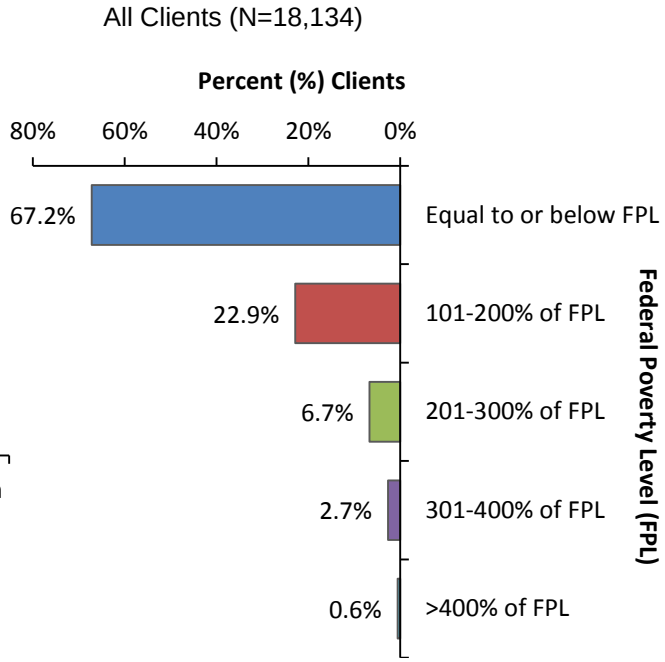


Figure 3.6. Distribution of All RWP Clients by Federal Poverty Level, FY 2013



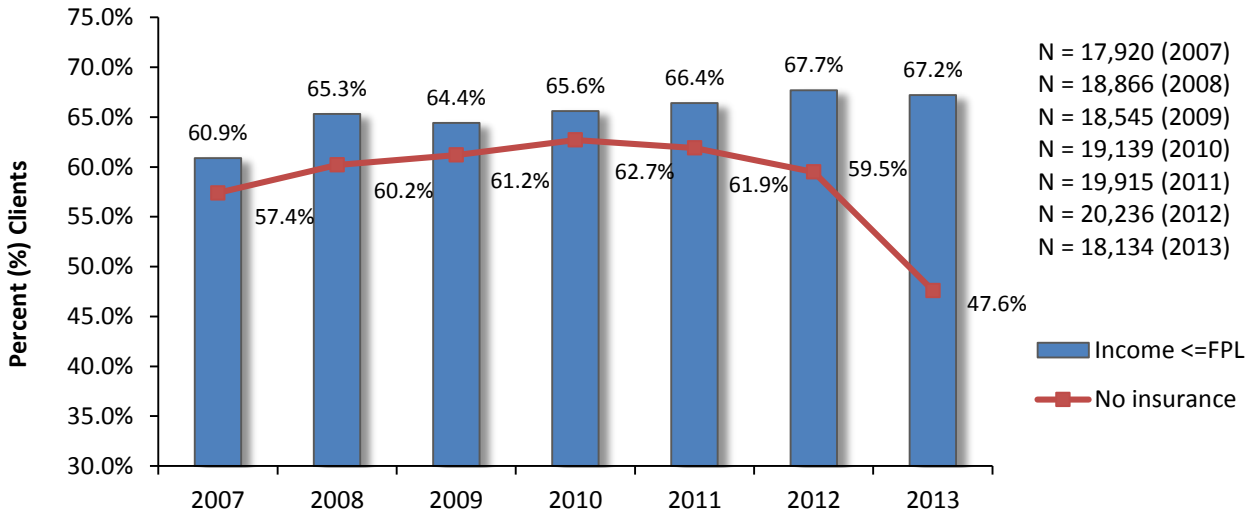
Data Source: Casewatch FY 2013 (March 2013 - February 2014)

The RWP is the payer of last resort; therefore, clients with other insurance types may access RWP services only if those services are not covered by their insurance, or if the client received services at a time when they were not covered by the other insurance. Private insurance was not used to pay for RWP services, nor were such clients eligible to receive RWP services for any services which their insurance covered.

For the second consecutive year since 2010 there was a decrease in uninsured status, with 47.6% of clients without any form of insurance coverage in FY 2013. This is down from a high of 62.7% of clients without any form of insurance reached in FY 2010, a likely result of Medi-Cal expansion and expanded insurance coverage as part of California's early adoption of health care reform efforts.

Between FY 2007 and FY 2013, the proportion of RWP clients who lived in poverty gradually increased. In FY 2007, 60.9% of clients lived at or below 100% FPL; in FY 2013, 67.2% lived at or below 100% FPL.

Figure 3.7. Proportion of RWP Clients Who Lived At or Below Federal Poverty Level and Proportion of RWP Who Had No Health Insurance, FY 2007 – 2013



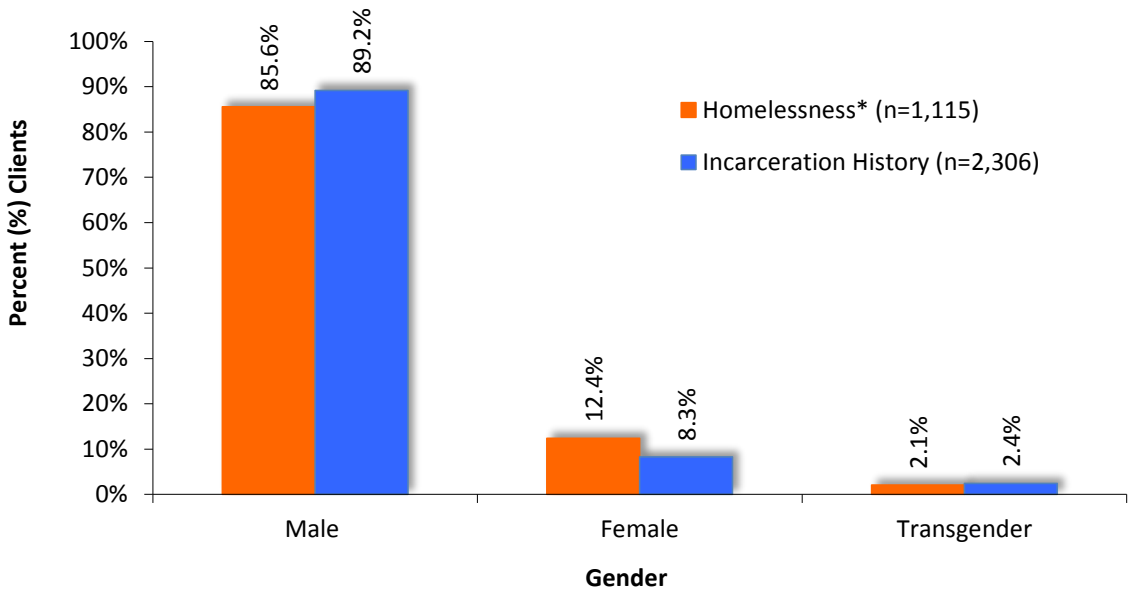
Data Source: Casewatch FY 2007 - 2013 (March 2007 - February 2014).

Clients with Special Needs: Homelessness, Incarceration, Mental Illness, and Substance Abuse

Many clients in the Ryan White care system face additional challenges aside from those associated with HIV that could affect their ability to seek care. At least two in ten RWP clients have been incarcerated at some point in their lives with 12.7% of all RWP clients (N=18,134) reporting having been incarcerated in the last 24 months. Another 9.3% reported incarceration more than two years ago. Approximately 6.1% of RWP clients in FY 2013 were homeless, defined as having non-permanent living situations, including homeless, transient or transitional. The homeless data do not include those RWP clients staying in institutions such as residential care/housing, correctional, and health care facilities.

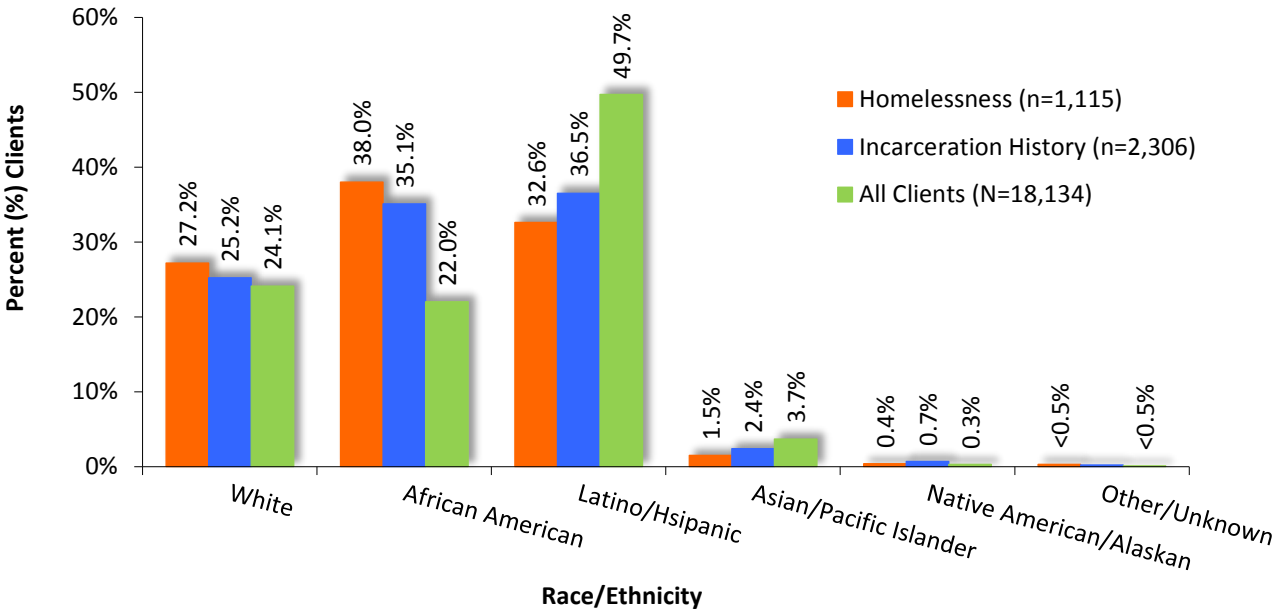
The following graphs illustrate some characteristics of clients with recent incarceration history and those who were homeless in FY 2013. Demographic information for clients in mental health and substance abuse treatment can be found in Chapters 4 and 5.

Figure 3.8. Gender Distribution of Homeless and Recently-Incarcerated Clients, FY 2013



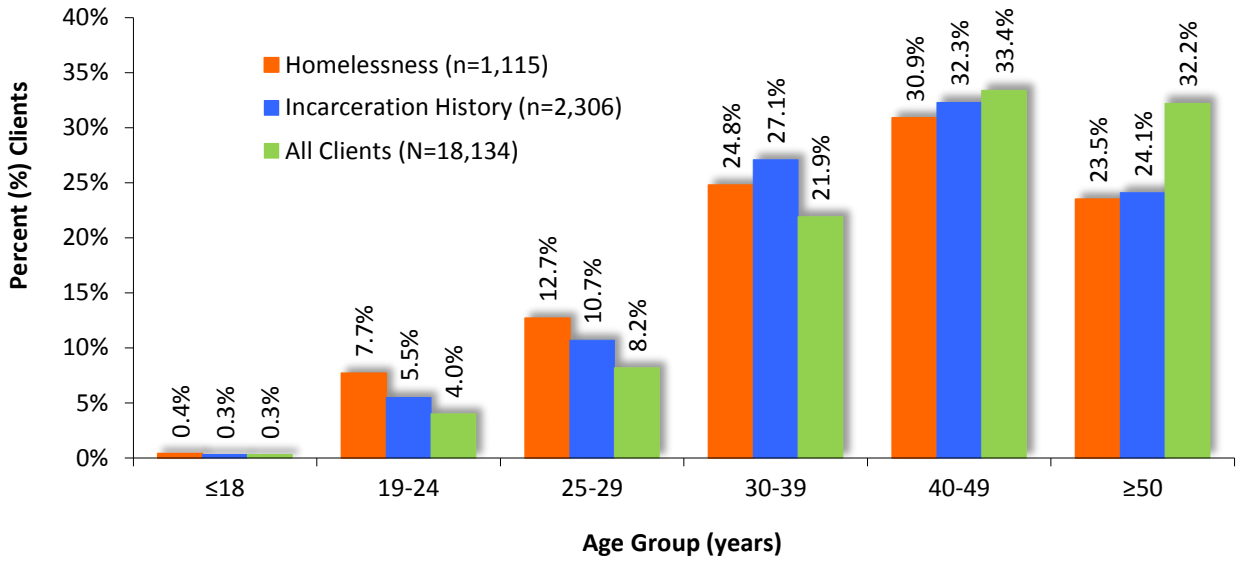
Data Source: Casewatch FY 2013 (March 2013 - February 2014)
***Note:** Homelessness does not include clients staying at residential, health care or correctional facilities. Incarceration history includes the period within the last 24 months.

Figure 3.9. Distribution of Clients by Race/Ethnicity among Homeless, Recently-Incarcerated, and All Clients, FY 2013



Data Source: Casewatch FY 2013 (March 2013 - February 2014)
Note: Incarceration history within the last 24 months

Figure 3.10. Distribution of Clients by Age among Homeless, Recently-Incarcerated, and All Clients, FY 2013



Data Source: Casewatch FY 2013 (March 2013 - February 2014)
Note: Incarceration history within the last 24 months

In addition, in FY 2013, 4.9% of RWP clients received DHSP-funded psychiatric treatment, while 7.8% of clients received psychotherapy services. Although just 2.6% of clients received DHSP-funded substance abuse residential services in FY 2013, the self-reported "current" risk behavior reported in Casewatch indicates that substance use among RWP clients was much more prevalent.

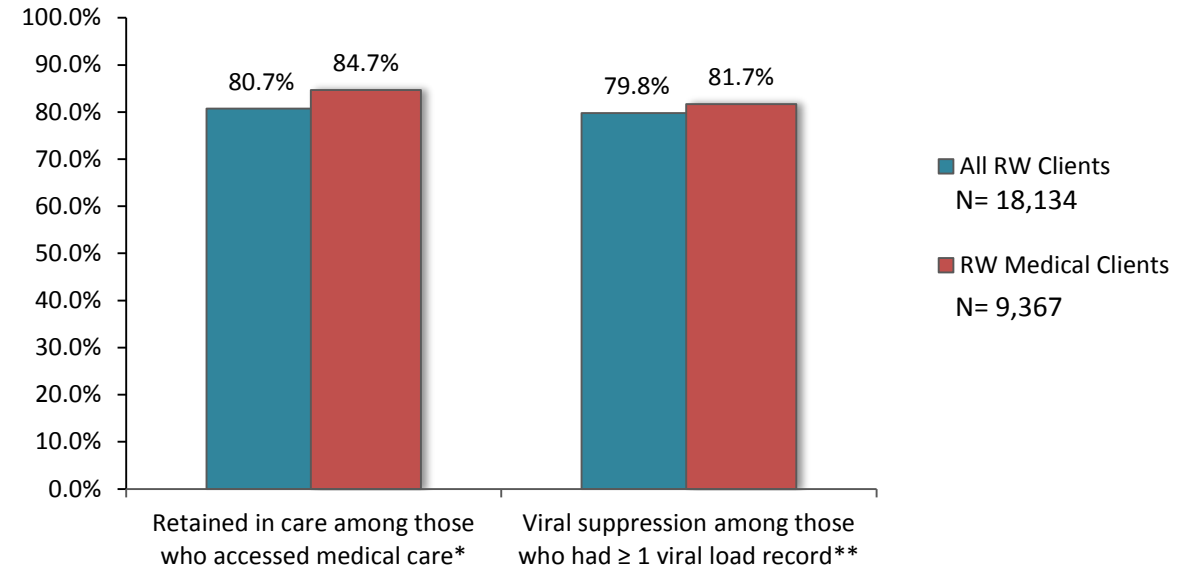
Client Health Outcomes

In this report, two health outcome variables are presented based on the matched Casewatch and HIV surveillance data: 1) Retention in care: defined as patients who have at least two Ambulatory Outpatient Medical (AOM) visits paid by Ryan White, viral loads, CD4 T-cell records, or genotyping tests during FY 2013 that are at least 3 months apart; and 2) Viral suppression: defined as having a most recent viral load record that was equal to or less than 200 copies/ml during FY 2013.

Clients in the DHSP Ryan White system of care showed good health outcomes in FY 2013; 80.7% were retained in care; and 79.8% had viral suppression (*Figure 3.11*). Compared with all clients in the DHSP Ryan White system, clients who accessed RWP AOM services had slightly better health outcomes, with 84.7% retained in care, and 81.7% achieving viral suppression.

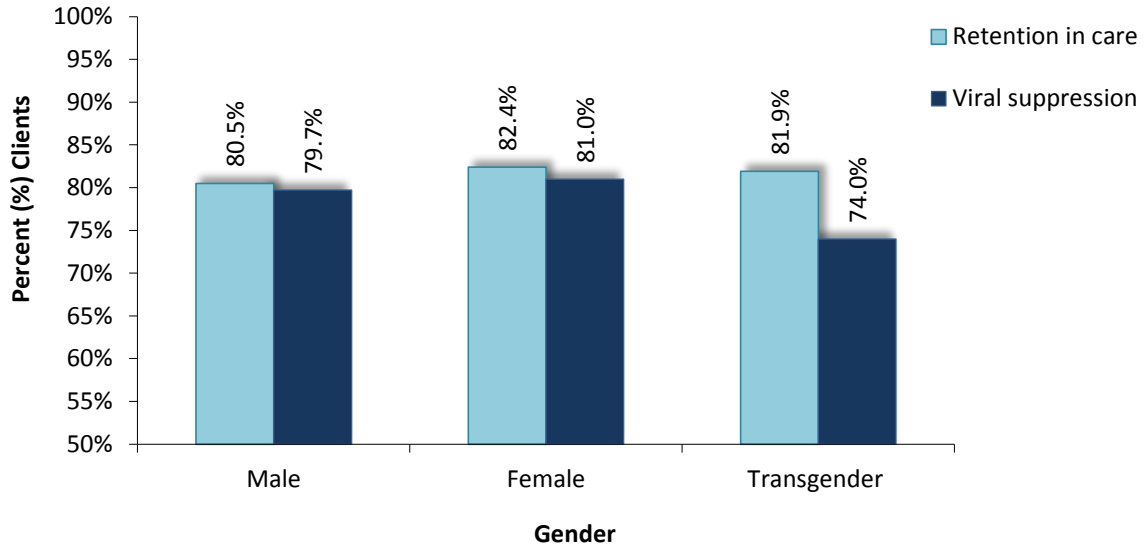
Health outcomes among various demographic groups are shown in *Figures 3.12* through *3.15*. In FY 2013, differences in retention in care among between males and female clients were not significant. However, transgender clients had a lower viral suppression rate (74.0%) compared with that of male (79.7%) and female (81.0%) clients (*Figure 3.12*).

Figure 3.11. Comparison of Two Health Outcomes Between All Clients and Clients Using RW Medical Care, FY 2013



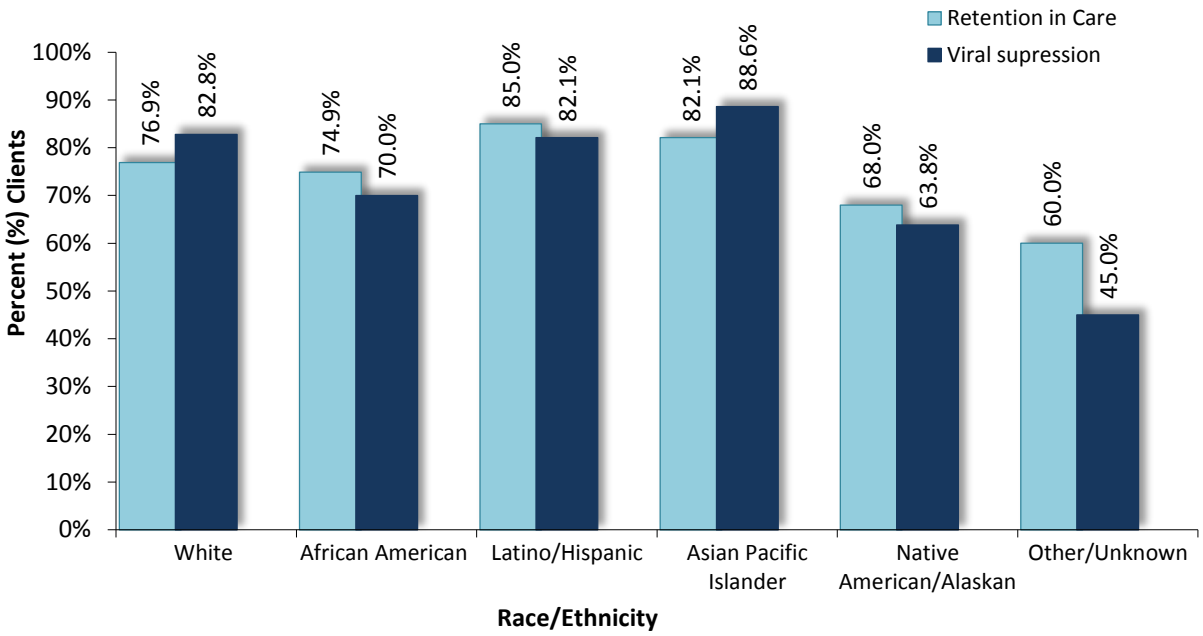
Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
*****Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

Figure 3.12. Retention and Viral Suppression Rates by Gender among All Clients, FY 2013



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
Note: 1. The denominators for each subgroup varies; refer to Table A.5 in the Appendix for details.
2. Retention in care is defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart. 3. Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

Figure 3.13. Retention and Viral Suppression Rates by Race and Ethnicity among All Clients, FY 2013



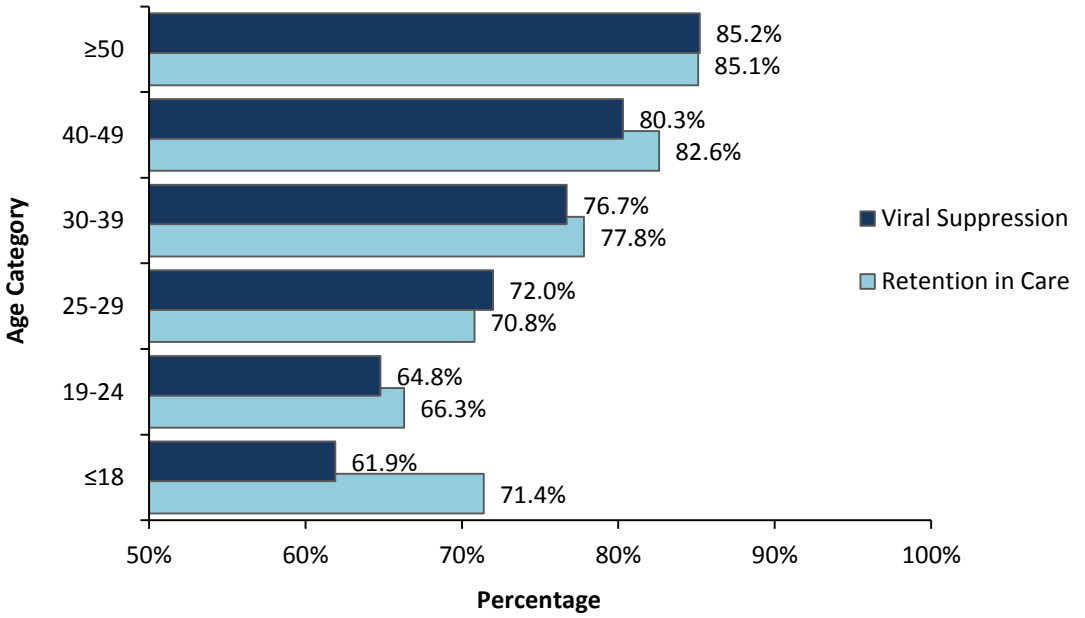
Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
Note: 1. The denominators for each subgroup varies; refer to Table A.5 in the Appendix for details.
2. Retention in care is defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart. 3. Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

African Americans had poorer health outcomes (74.9% retained in care and 70.0% achieved viral suppression) compared with Whites, Latino/as and Asians/Pacific Islanders. Although Native Americans/Alaskan Natives and clients with other or unknown race/ethnicity appeared to have low retention-in-care and viral suppression rates (68.0% retention and 63.8% viral suppression for Native Americans/Alaskan Natives, and 60.0% retention and 45.0% viral suppression among clients with other/unknown race/ethnicities), the number of these clients was too small to draw conclusions (*Figure 3.13*).

Clients under 30 had lower retention and viral suppression rates. Younger clients (under 25) had poorer health outcomes: 64.8% among 19-24 years old and 61.9% among those 18 years old and younger achieved viral suppression. The proportion of clients 18 years and younger who were retained in care was similar to that of clients ages 25-29 (71.4% and 70.8% respectively)—both were lower than that of other, older age groups—the worst retention-in-care was seen among young adults 19-24 years old (66.3%). Clients 40 years and older demonstrated better health outcomes, with clients 50 years old showing the highest retention and viral suppression rates (85.1% and 85.2% respectively). See *Figure 3.14* for detail.

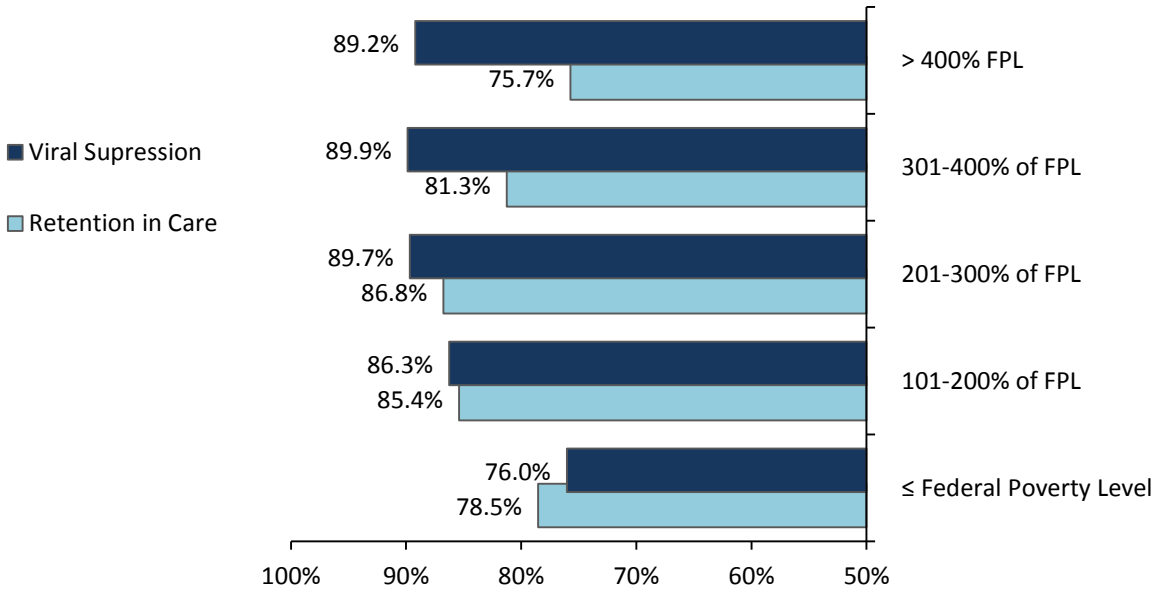
Health outcomes by client income level showed that clients with income at or below federal poverty level (FPL) had lower retention and viral suppression rates than clients at other income levels (*Figure 3.15*). Data also indicated lower retention rate for clients above 400% FPL. Because the number of clients with income greater than 400% FPL was small, this result should be interpreted with caution.

Figure 3.14. Retention and Viral Suppression Rates by Age among All Clients (N = 18,134), FY 2013



Data Source for Figures 2.14 and 2.15: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
Note: 1. The denominators for each subgroup varies; refer to Table A.5 in the Appendix for details.
2. Retention in care is defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart. 3. Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

Figure 3.15. Retention and Viral Suppression Rates by Income Level among All Clients (N = 18,134), FY 2013



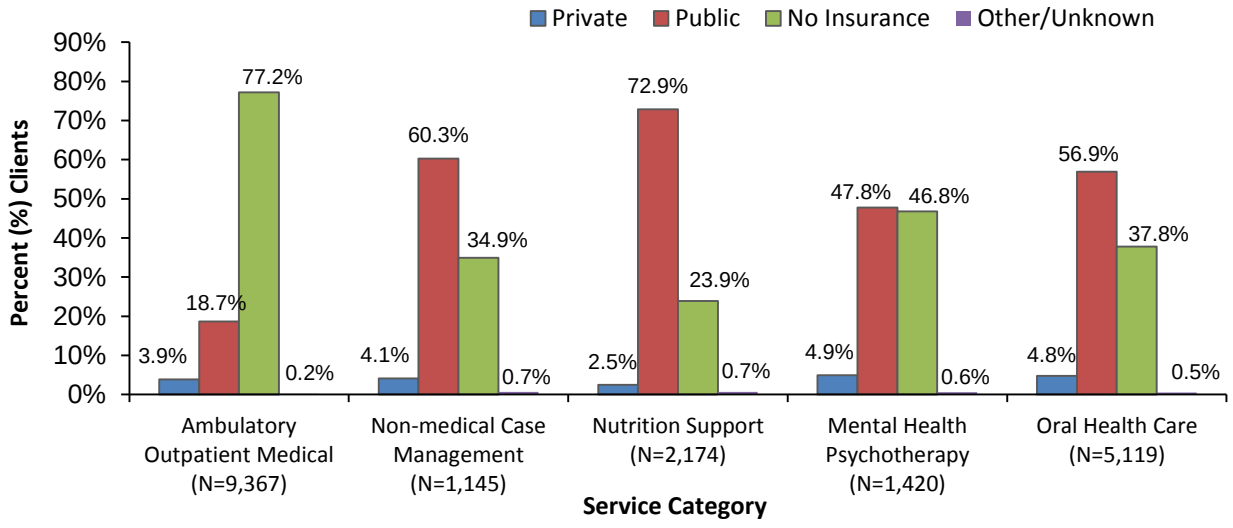
Service Utilization by Service Category

Table 3.1. Services Accessed by All RWP Clients, FY 2013

Type of RWP Service	N	%
All Clients	**18,134**	**100.0**
Ambulatory Outpatient Medical*	9,367	51.7
Medical Care Coordination**	7,390	40.8
Oral Health Care	5,119	28.2
Benefits Specialty	2,969	16.4
Nutrition Support	2,174	12.0
Mental Health Psychotherapy	1,420	7.8
Transitional Case Management	1,213	6.7
Non-medical Case Management	1,145	6.3
Mental Health Psychiatry	890	4.9
Substance Abuse Services - Residential	412	2.3
Home-based Case Management	292	1.6
Residential Care/Housing Services	156	0.9
Substance Abuse Services - Outpatient	50	0.3
Medical Nutrition Therapy (SPA 1 only)	59	0.3
Language Services***	11	0.1

Data Source: Casewatch FY 2013 (March 2013 - February 2014)
*Received at least one medical visit within the year.
** Number and percentage indicate those who were screened for MCC.
***Includes sign language interpretation direct interpretation service clients only.

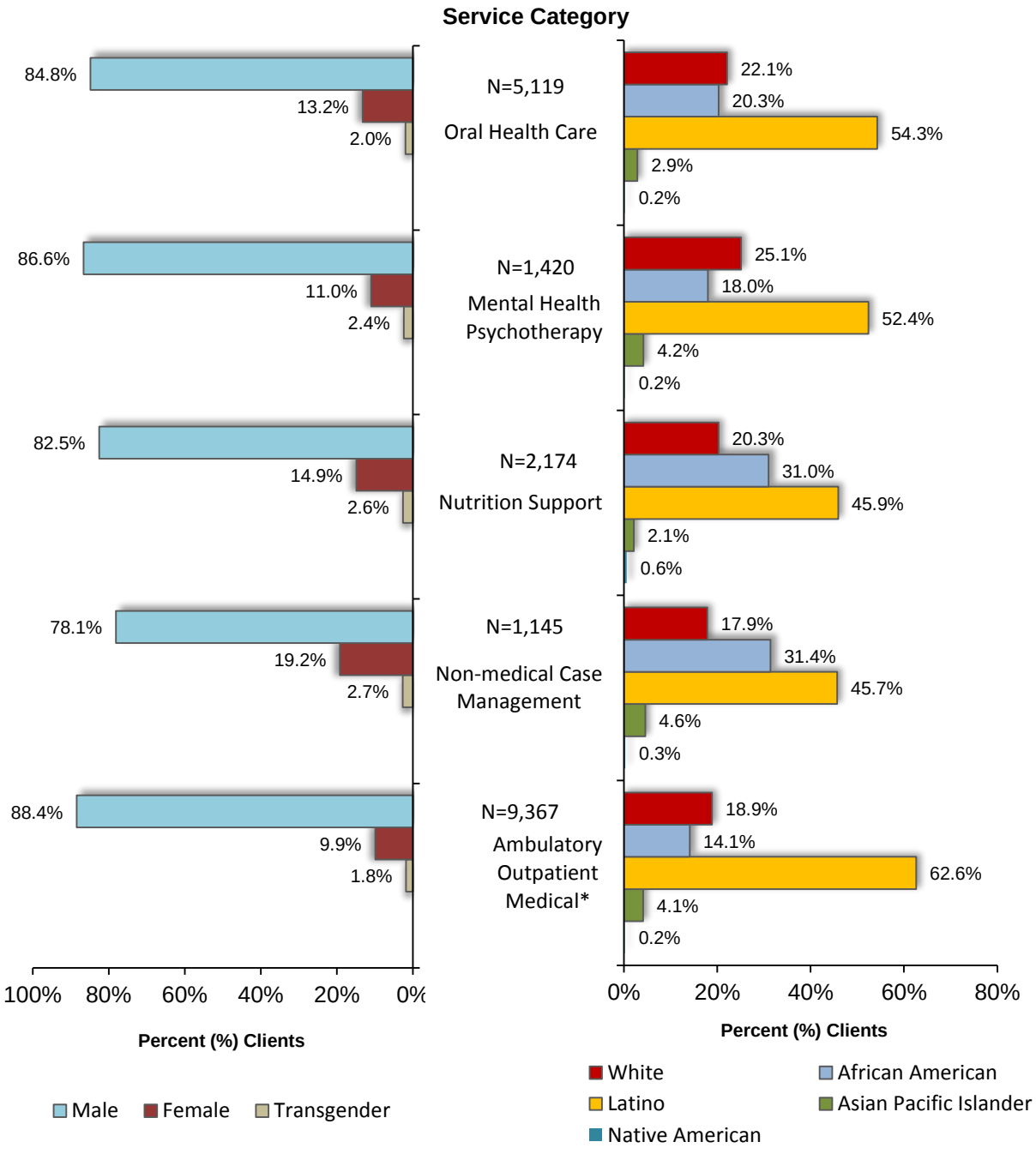
Figure 3.16. Key Services Accessed by Type of Insurance, FY 2013



Data Source: Casewatch FY 2013 (March 2013 - February 2014)
*Clients who received at least one Ambulatory Outpatient Medical (AOM) visit within the year

Figure 3.17. Key Services Accessed by Gender, FY 2013

Figure 3.18. Key Services Accessed by Race/Ethnicity, FY 2013†



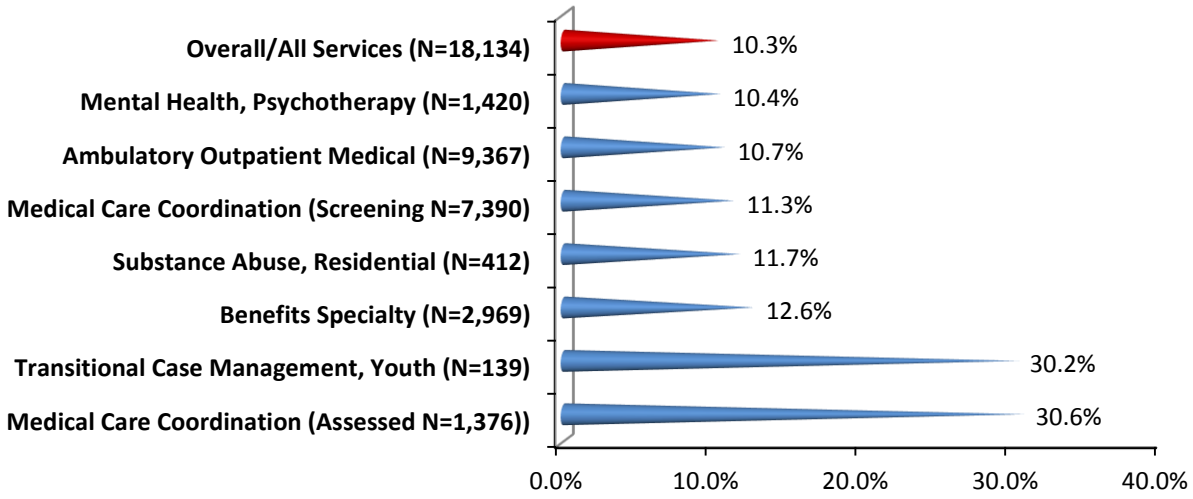
Data Source: Casewatch FY 2013 (March 2013 - February 2014)
*Clients who received at least one Ambulatory Outpatient Medical (AOM) visit within the year
†Other/Unknown not shown.

Impact of Services

The majority of DHSP-funded HIV care and treatment services are intended to increase access to and retention in HIV medical care so that clients can have consistent HIV care and maintain optimal health outcomes. Some of these services have components that are designed to connect newly diagnosed HIV-positive individuals or clients who have fallen out of care to HIV medical care while others are designed to maintain an HIV-positive individual in care

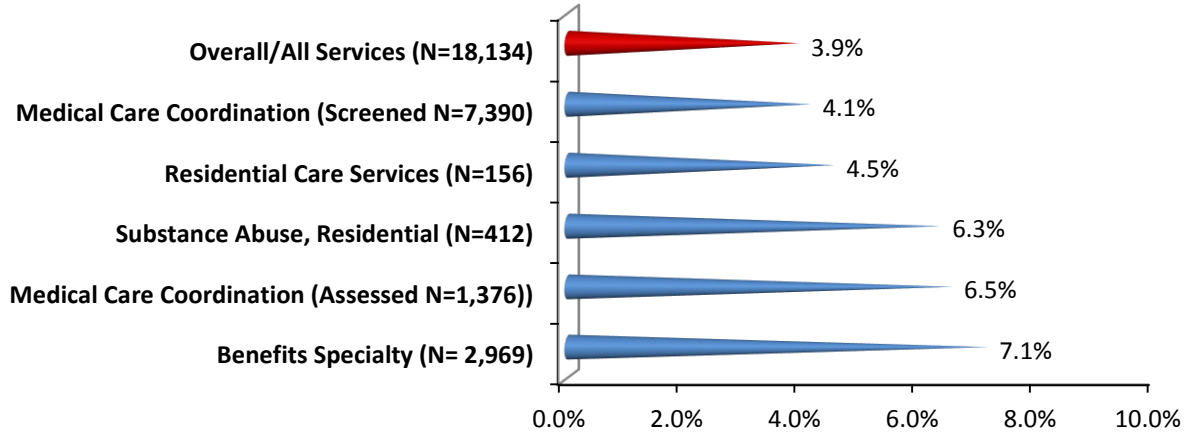
HIV care access and health outcomes for clients utilizing each DHSP-supported HIV care service are outlined in Chapters 4 and 5. Highlights of the impact of these services are illustrated in the figures below.

Figure 3.19. Top Service Categories with Higher Proportions of Patients New to the Ryan White Care System in FY 2013 Compared with Proportion for All Services



Data Source for Figure 3.19-20: Casewatch FY 2013 (March 2013 - February 2014)
Note: Medical Nutrition Therapy and Substance Abuse Outpatients are excluded due to small number of clients; other categories not shown indicate that their percentages of new clients were lower than that of all services (10.3%).

Figure 3.20. Top Service Categories with Higher Proportions of Patients Returned to the Ryan White Care System in FY 2013 Compared with Proportion for All Services



Chapter 4. Core Medical Services

In FY 2013, DHSP funded the following core medical services for HIV/AIDS care and treatment:

11. Ambulatory Outpatient Medical Services
12. Medical Specialty
13. Oral Health Care
14. Mental Health, Psychiatry
15. Mental Health, Psychotherapy
16. Medical Care Coordination
17. Substance Abuse Treatment
18. ADAP Enrollment
19. Case Management, Home-based
20. Medical Nutrition Therapy

4.1 Ambulatory Outpatient Medical Services

HRSA Definition: Outpatient/Ambulatory Medical Care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history intake, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Commission Definition/Guidance: Medical Outpatient Services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS including physicians, physician assistants and/or nurse practitioners licensed to practice by the State of California.

What DHSP Funds: Ambulatory Outpatient Medical Care offers free HIV medical care provided by a licensed health care professional such as a physician, nurse practitioner or a physician's assistant. It includes: medical visits; laboratory testing; physical evaluations; drug prescriptions; medication adherence counseling; health education and referrals to specialty care.

Funding Sources: RWP Part A, Net County Cost (NCC), and State ADAP

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$16,433,198	$0	$331,425	$16,764,623

*NCC – expenditures - $48,785; State ADAP - $282,640

Expenditures for Medical Specialty are captured in Section 4.2. Medical Specialty, and are not included here.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
9,367 (Visits)	Encounters*	33,526
1,673 (Radiology)		
2,773 (Pharmaceuticals)		

*Encounters include new and established outpatient medical visits, exams and consultation.

Table 4.1. Demographic Characteristics of Clients Receiving Ambulatory Outpatient Medical Services, FY 2013

Demographic Characteristic	Ambulatory Outpatient Medical Services (N=9,367) N	%
Gender		
Male	8,277	88.4%
Female	924	9.9%
Transgender	166	1.8%
Race/Ethnicity		
White	1,768	18.9%
African American	1,325	14.1%
Latino	5,868	62.6%
Asian Pacific Islander	386	4.1%
Native American	17	0.2%
Other/Unknown	<5	0.0%
Age Group (years)		
≤ 18	12	0.1%
19-24	351	3.7%
25-29	892	9.5%
30-39	2,540	27.1%
40-49	3,416	36.5%
≥ 50	2,156	23.0%
Primary Medical Insurance		
Private	364	3.9%
Public	1,747	18.7%
No Insurance	7,235	77.2%
Other	21	0.2%
Unknown	0	0.0%

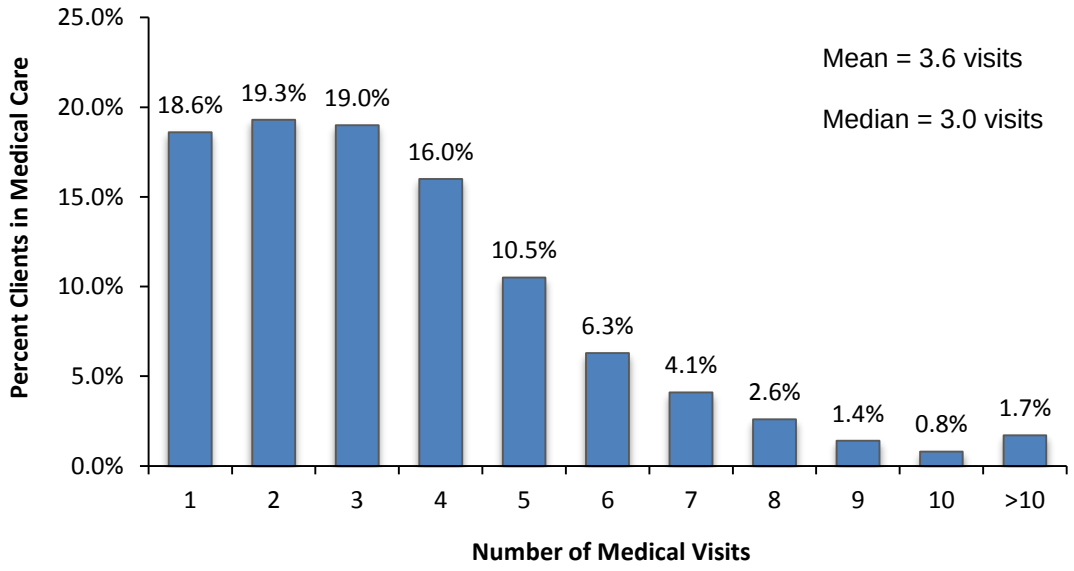
Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 4.2. Care Access and Health Outcomes of Clients Receiving Ambulatory Outpatient Medical (AOM) Services, FY 2013

Demographic Characteristic	Ambulatory Outpatient Medical Services (N=9,367) N	%
Receiving Ryan White (RW) Funded Medical Care	9,367	100.0%
New Client to RW System of Care	1,003	10.7%
Returning Client to RW System of Care	272	2.9%
Clients Retained in HIV Care*	7,934	84.7%
Clients with Viral Suppression**	7,478	79.8%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY2013.

Figure 4.1. Distribution of Clients by Frequency of Medical Visits, FY 2013 (N=9,367)



Data Source: Casewatch FY 2013 (March 2013 - February 2014)

4.2 Medical Specialty Services

HRSA Definition: HRSA does not have a specific definition for Medical Specialty Services. All medical specialty care is included under HRSA's definition of Outpatient/Ambulatory Medical Care.

Commission Definition/Guidance: Medical Specialty Services provide consultation, diagnosis and therapeutic services for medical complications beyond the scope of primary medical and nursing care for people living with HIV. Services include: cardiology; dermatology; ear, nose and throat specialty; gastroenterology; gynecology; neurology; ophthalmology; oncology; oral health; pulmonary medicine; podiatry; proctology; general surgery; urology; nephrology; orthopedics; and obstetrics.

What DHSP Funds: HIV/AIDS Medical Specialty Services (MSS) offer free medical specialty services provided by a licensed health care professional such as a physician, nurse practitioner or a physician's assistant. The MSS Program accepts eligible patient referrals from outpatient ambulatory medical care providers to treat complications related to HIV disease. Such medical specialties include, but are not limited to: cardiology, colorectal/proctology, dermatology, ear, nose, and throat, endocrinology, hepatology, gastroenterology, general surgery, gynecology, neurology, nephrology, ophthalmology, oncology, orthopedics, pain management, pulmonary, podiatry, rheumatology, urology. Services also cover limited diagnostic imaging tests such as ultrasound, echocardiography, CT scan, MRI, DEXA bone scan.

Funding Sources: RWP Part A

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$1,392,589	$0	$0	$1,392,589

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
2,190	Initial and follow-up visits	4,749

4.3 Oral Health Care

HRSA Definition: Oral Health Care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Oral health services provided under contract with DHSP include diagnostic, prophylactic, and therapeutic services rendered by dentists, dental hygienists, registered dental assistants, and other similarly trained professional practitioners. Services also

include obtaining a comprehensive medical history and consulting primary medical providers as necessary; providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral health conditions; providing or referring patients, as needed, to specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners, and patient education.

Funding Sources: RWP Part A, Part B, MAI, and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$1,502,359	$1,764,523	$1,790,479	$5,057,361

*MAI expenditures - $1,722,301; NCC expenditures - $68,178.

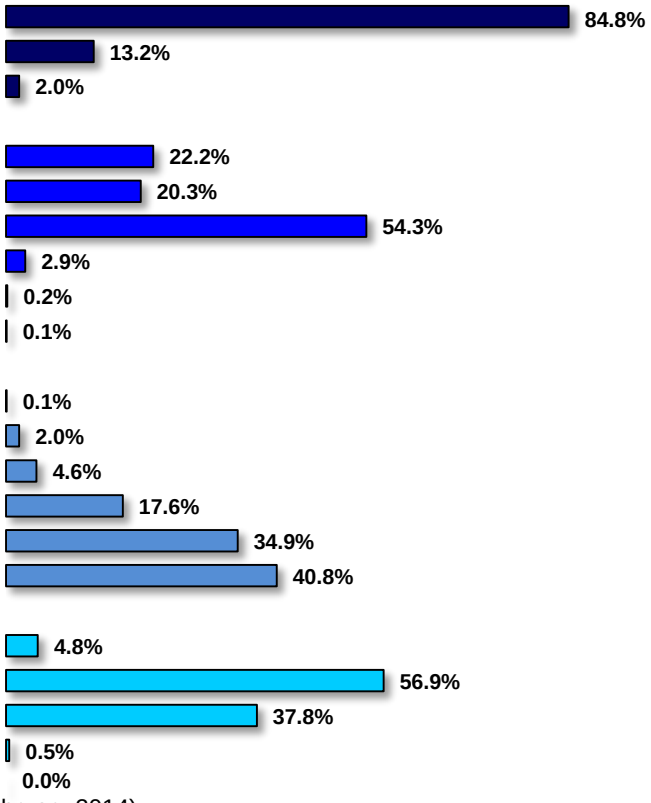
Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
5,119	Encounters*	54,375

*Includes oral evaluation, prophylaxis and over 170 CDT dental procedural codes.

Table 4.3. Demographic Characteristics of Clients Receiving Oral Health Care, FY 2013

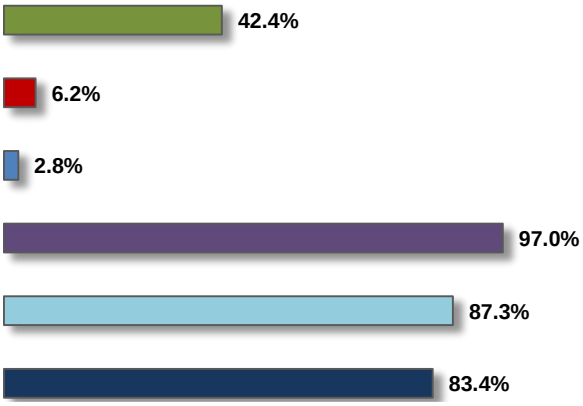
Demographic Characteristic	Oral Health Care (N=5,119) N	%
Gender		
Male	4,339	84.8%
Female	676	13.2%
Transgender	104	2.0%
Race/Ethnicity		
White	1,138	22.2%
African American	1,038	20.3%
Latino	2,778	54.3%
Asian Pacific Islander	150	2.9%
Native American	11	0.2%
Other/Unknown	<5	0.1%
Age Group (years)		
≤ 18	6	0.1%
19-24	102	2.0%
25-29	237	4.6%
30-39	899	17.6%
40-49	1,788	34.9%
≥ 50	2,087	40.8%
Primary Medical Insurance		
Private	147	4.8%
Public	1,695	56.9%
No Insurance	2,032	37.8%
Other	19	0.5%
Unknown	0	0.0%



Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 4.4. Care Access and Health Outcomes of Clients Receiving Oral Health Services, FY 2013

Demographic Characteristic	Oral Health Services (N=5,119) N	%
Receiving Ryan White (RW) Funded Medical Care	2,169	42.4%
New Client to RW System of Care	315	6.2%
Returning Client to RW System of Care	144	2.8%
Clients Accessed Any HIV Medical Care[o]	4,963	97.0%
Clients Retained in HIV Care*	4,470	87.3%
Clients with Viral Suppression**	4,268	83.4%



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

4.4 Mental Health, Psychiatry

HRSA Definition: HRSA does not have a specific definition for Mental Health, Psychiatry. It groups both psychiatry and psychotherapy or counseling under a broad Mental Health Services category. Under the HRSA definition, Mental Health Services include both psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional, licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Commission Definition/Guidance: Mental Health, Psychiatry is a service that attempts to stabilize mental health conditions while improving and sustaining quality of life. It is provided by professionals who are licensed to treat psychiatric disorders in the State of California. Service components include client registration/intake, psychiatric assessment, treatment provision (psychiatric medication assessment, prescription and monitoring), and crisis intervention.

What DHSP Funds: Mental Health, Psychiatry services provide psychiatric diagnostic evaluation and psychotropic medication by a psychiatrist, psychiatric resident, or registered nurse/nurse practitioner under the supervision of a psychiatrist. Service components include client registration/intake; psychiatric assessment; treatment provision (psychiatric medication assessment, prescription and monitoring); and crisis intervention.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$910,234	$0	$15,089	$925,323

*NCC expenditures - $15,089

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
890	Hours	1,409

Table 4.5. Demographic Characteristics of Clients Receiving Mental Health, Psychiatry, FY 2013

Demographic Characteristic	Mental Health Psychiatry (N=890) N	%
Gender		
Male	777	87.3%
Female	97	10.9%
Transgender	16	1.8%
Race/Ethnicity		
White	295	33.1%
African American	137	15.4%
Latino	426	47.9%
Asian Pacific Islander	30	3.4%
Native American	<5	0.2%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	<5	0.1%
19-24	22	2.5%
25-29	68	7.6%
30-39	198	22.2%
40-49	356	40.0%
≥ 50	245	27.5%
Primary Medical Insurance		
Private	33	3.7%
Public	430	48.3%
No Insurance	426	47.9%
Other	<5	0.1%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 4.6. Care Access and Health Outcomes of Clients Receiving Mental Health, Psychiatry Services, FY 2013

Demographic Characteristic	Mental Health Psychiatry Services (N=890) N	%
Receiving Ryan White (RW) Funded Medical Care	593	66.6%
New Client to RW System of Care	73	8.2%
Returning Client to RW System of Care	19	2.1%
Clients Accessed Any HIV Medical Care[o]	879	98.8%
Clients Retained in HIV Care*	744	83.6%
Clients with Viral Suppression**	722	81.1%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

4.5 Mental Health, Psychotherapy

HRSA Definition: HRSA does not have a specific definition for Mental Health, Psychotherapy. It groups both psychiatry and psychotherapy or counseling under a broad Mental Health Services category. (See HRSA definition of Mental Health Services above.)

Commission Definition/Guidance: Mental Health, Psychotherapy is a service that attempts to improve and sustain a client's quality of life. It includes client intake; bio-psychosocial assessment; treatment planning; treatment provision in individual, family, conjoint or group modalities; drop-in psychotherapy groups; and crisis intervention.

What DHSP Funds: Mental Health, Psychotherapy services provide comprehensive mental health assessments, treatment plans, and psychotherapy by licensed mental health professionals or graduate students in training under the supervision of licensed mental health professionals. Services include client intake; bio-psychosocial assessment; treatment planning; treatment provision in individual, family, conjoint or group modalities; drop-in psychotherapy groups; and crisis intervention.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Source:	Part A	Part B	Other*	Total
Expenditures	$1,817,944	$0	$110,990	$1,928,934

*NCC expenditures - $110,990

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
1,420	Hours	13,904

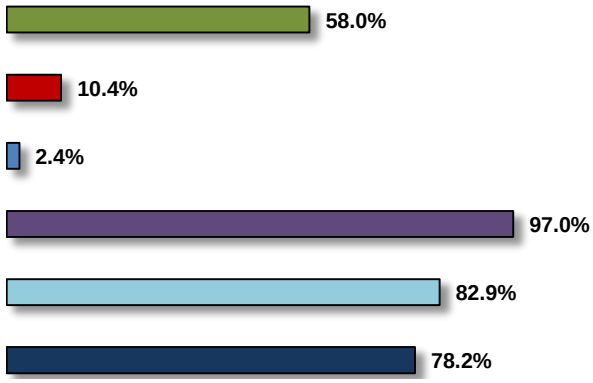
Table 4.7. Demographic Characteristics of Clients Receiving Mental Health, Psychotherapy, FY 2013

Demographic Characteristic	Mental Health Psychotherapy (N=1,420) N	%
Gender		
Male	1,230	86.6%
Female	156	11.0%
Transgender	34	2.4%
Race/Ethnicity		
White	357	25.1%
African American	256	18.0%
Latino	744	52.4%
Asian Pacific Islander	59	4.2%
Native American	<5	0.2%
Other/Unknown	<5	0.1%
Age Categories		
≤ 18	<5	0.3%
19-24	63	4.4%
25-29	115	8.1%
30-39	298	21.0%
40-49	509	35.8%
≥ 50	431	30.4%
Primary Medical Insurance		
Private	69	4.9%
Public	679	47.8%
No Insurance	664	46.8%
Other	8	0.6%
Unknown	0	0.0%

Data Source: Casewatch FY 2012 (March 2012 - February 2013).

Table 4.8. Care Access and Health Outcomes of Clients Receiving Mental Health, Psychotherapy Services, FY 2013

Demographic Characteristic	Mental Health Psychotherapy Services (N=1,420) N	%
Receiving Ryan White (RW) Funded Medical Care	824	58.0%
New Client to RW System of Care	147	10.4%
Returning Client to RW System of Care	34	2.4%
Clients Accessed Any HIV Medical Care[o]	1,378	97.0%
Clients Retained in HIV Care*	1,177	82.9%
Clients with Viral Suppression**	1,111	78.2%



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

4.6 Medical Care Coordination

HRSA Definition: HRSA does not have a service category named Medical Care Coordination (MCC). MCC as contracted by DHSP today falls under HRSA definition of Medical Case Management (including Treatment Adherence). Medical Case Management is a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) client monitoring to assess the efficacy of the plan; and 5) periodic re-evaluation and adaptation of the plan as necessary. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication.

Commission Definition/Guidance: MCC services are patient-centered activities which focus on access, utilization, retention and adherence to primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. Medical care coordination services espouse a coordinated approach to service provision across the many systems a person living with HIV encounters.

What DHSP Funds: Consistent with the HRSA definition of medical case management and the Commission standards, the MCC service model funded by DHSP is a multi-disciplinary team approach that integrates medical and non-medical case management by coordinating behavioral interventions and support services with medical care to promote improved health outcomes. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction.

The core MCC team is comprised of:

Medical Care Manager (MCM): ensures the patient's medical needs are met and their care is coordinated. MCM also assists patients as needed through the delivery of brief interventions focused on patient education, treatment adherence, managing side effects, medical nutrition therapy, co-infections, preventative care and risk reduction. To the extent possible, it is highly recommended that the MCM acts as team lead given the intervention is imbedded within a clinic setting and seeks to affect biomedical outcomes. The MCM must be a licensed registered nurse (RN) in the state of California.

Patient Care Manager (PCM): ensures the comprehensive and thorough assessment of a patient's psychosocial needs, particularly as they relate to mental health and substance use issues. PCM also assists patients as needed through the delivery of brief interventions focused on substance misuse, mental health, risk reduction and disclosure/partner notification. The PCM must have a Master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services.

Case Worker(s) (CW): addresses the patient's socioeconomic needs and assists the MCM and the PCM with patient monitoring, reassessment, service linkages, plan updating, patient follow-up, and tracking outcomes. Additionally, the Case Worker acts as the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care seamlessly and in a timely fashion. The CW must have a Bachelor's degree in Nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services, and/or be a licensed vocational nurse (LVN).

Funding Sources: RWP Part A, Net County Cost, and Minority AIDS Initiative

Expenditures and Funding Sources:

Funding Source:	Part A	Part B	Other*	Total
Expenditures	$5,111,031	$0	$1,133,544	$6,244,575

*NCC expenditures - $266,368; MAI expenditures - $867,176

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
7,390 (Screened)	Encounters	10,227
1,376 (Active*)	Encounters	1,817

*****Active MCC clients indicate clients who received the comprehensive MCC assessment that determines acuity levels for appropriate intervention levels and frequencies of interventions and engagements.

Table 4.9. Demographic Characteristics of Clients Receiving Screening for Medical Care Coordination Services, FY 2013

Demographic Characteristic	Medical Care Coordination (N=7,390) N	%
Gender		
Male	6,223	84.2%
Female	1,025	13.9%
Transgender	142	1.9%
Race/Ethnicity		
White	1,716	23.2%
African American	1,703	23.0%
Latino	3,648	49.4%
Asian Pacific Islander	291	3.9%
Native American	25	<1%
Other/Unknown	7	<1%
Age Categories		
≤ 18	23	<1%
19-24	381	5.2%
25-29	676	9.1%
30-39	1,709	23.1%
40-49	2,446	33.1%
≥ 50	2,153	29.1%
Primary Medical Insurance		
Private	389	5.3%
Public	3,846	52.0%
No Insurance	3,117	42.2%
Other	38	0.5%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013- February 2014)

Table 4.10. Care Access and Health Outcomes of Clients Screened for MCC, FY 2013

Demographic Characteristic	Screened for Medical Care Coordination (N=7,390) N	%
Receiving Ryan White (RW) Funded Medical Care	3,580	48.4%
New Client to RW System of Care	837	11.3%
Returning Client to RW System of Care	305	4.1%
Clients Accessed Any HIV Medical Care°	7,204	97.5%
Clients Retained in HIV Care*	5,807	78.6%
Clients with Viral Suppression**	5,849	79.1%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
Note: see Table 4.12 for definitions of access to HIV care, retained in HIV care, and viral suppression.

Table 4.11. Demographic Characteristics of Clients Receiving Comprehensive Medical Care Coordination Assessment and Actively Enrolled in Services, FY 2013

Demographic Characteristic	Medical Care Coordination (N=1,376) N	%
Gender		
Male	1,163	84.5%
Female	186	13.5%
Transgender	27	2.0%
Race/Ethnicity		
White	290	23.2%
African American	362	26.3%
Latino	673	48.9%
Asian Pacific Islander	44	3.2%
Native American	<5	<1%
Other/Unknown	<5	<1%
Age Categories		
≤ 18	8	<1%
19-24	130	9.4%
25-29	183	13.3%
30-39	344	25.0%
40-49	421	30.6%
≥ 50	290	21.1%
Primary Medical Insurance		
Private	42	3.1%
Public	828	60.2%
No Insurance	497	36.1%
Other/Unknown	9	0.7%

Data Source: Casewatch FY 2013 (March 2013- February 2014)

Table 4.12. Care Access and Health Outcomes of Active MCC Clients, FY 2013

Demographic Characteristic	Active Medical Care Coordination Services (N=1,376) N	%
Receiving Ryan White (RW) Funded Medical Care	659	47.9%
New Client to RW System of Care	421	30.6%
Returning Client to RW System of Care	90	6.5%
Clients Accessed Any HIV Medical Care[o]	1,351	98.2%
Clients Retained in HIV Care*	999	72.6%
Clients with Viral Suppression**	863	62.7%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

4.7 Substance Abuse, Treatment

HRSA Definition: Substance Abuse Services (Outpatient) are the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Commission Definition/Guidance: HIV Substance Abuse Treatment Services include: the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

What DHSP Funds: HIV Substance Abuse Treatment Services provided under contract with DHSP in FY 2013 include substance abuse day treatment and substance abuse residential detoxification. Residential Detox is reported under Substance Abuse, Residential in Chapter 5, following HRSA definition of core medical and support services.

Substance Abuse Day Treatment Services are non-residential therapeutic services that provide a minimum of five hours of planned activities per day. Programs are designed to be more intensive than outpatient visits, but less extensive than 24 hour residential services. At minimum, services (including individual and group sessions and structured therapeutic activities) should be offered at least five hours per day, five days per week. The length of stay in HIV substance abuse day treatment services is not to exceed 90 days. Extensions can be made if the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine (ASAM) and DHSP approves the request for extension.

Funding Sources: State CSAT (pass-through from SAMSHA Center for Substance Abuse Treatment)

Expenditures and Funding Sources: RWP Part B and State (pass-through) CSAT

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$0	$65,793	$65,793

*State CSAT = $65,793

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
50 (Day Treatment Clients)	Treatment Days	1,517

Table 4.13. Demographic Characteristics of Clients Receiving Substance Abuse Day Treatment Services, FY 2013

	Substance Abuse Treatment Services (N=50)	
	N	%
Gender		
Male	47	89.8%
Female	<5	9.0%
Transgender	<5	1.2%
Race/Ethnicity		
White	31	62.0%
African American	5	10.0%
Latino	12	24.0%
Asian Pacific Islander	<5	4.0%
Native American	0	0.0%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	0	0.0%
19-24	<5	2.0%
25-29	8	16.0%
30-39	18	36.0%
40-49	17	34.0%
≥ 50	6	12.0%
Primary Medical Insurance		
Private	<5	2.0%
Public	30	60.0%
No Insurance	19	38.0%
Other	0	0.0%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	18	36.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)
*Clients who received at least one medical visit within the year

4.8 AIDS Drug Assistance Program (ADAP) Enrollment

HRSA Definition: HRSA does not have a specific service category called ADAP Enrollment.

Commission Definition/Guidance: ADAP Enrollment assists clients with enrolling in the State-administered program authorized under Part B of the RWP. ADAP provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medi-Cal, or Medicare. Enrollment coordinators supervise ADAP services at individual sites.

What DHSP Funds: Fee-for-service reimbursements for ADAP enrollment based on client enrollment and recertification in ADAP.

Funding Sources: State of California Office of AIDS (ADAP)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other**	Total
Expenditures	0	0	$282,640	$282,640

*State ADAP - $282,640 (ADAP Enrollment)

Service Utilization:

Services	Total Clients Served
New enrollment	1,840
Re-certification	17,086

Data Source: Ramsell Monthly Data Report (March 2013 – February 2014), including City of Long Beach and City of Pasadena.

4.9 Case Management, Home-Based

HRSA Definition*:* HRSA does not have a specific category called "Home-based Case Management." The standards of care and currently funded services in Los Angeles County fit under HRSA's definition of Home and Community-based Health Services.

Home and Community-based Health Services (a core service) include skilled health services provided to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostic testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospital services, nursing home and other long term care facilities are NOT included.

Commission Definition/Guidance**:** Case Management, Home-based, includes client-centered case management and social work activities that focus on care for persons living with HIV who are functionally impaired and require intensive home and/or community-based services. Services are conducted by qualified registered nurse case managers and master's level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, support and collaboration.

What DHSP Funds: Home-based Case Management services provided under contract with DHSP include: intake; assessment; service planning; attendant care; homemaker services; psychosocial case management; mental health services; and provision of durable medical equipment and nutritional supplements.

Funding Sources: RWP Part B

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$2,587,953	$0	$2,587,953

Service Utilization:

Services	Total Clients Served*	Service Unit Definition	Service Units Provided
Attendant care	50	Attendant care hours	13,394
Homemaker services	116	Homemaker hours	33,083
Case management	291	Case management hours	13,604
Psychotherapy	39	Psychotherapy hours	1,330
Nutrition	56	Nutrition encounters	4,922
Durable medical equipment	6	Durable medical equipment items	43

Note: Clients may be counted in more than one category if they accessed services in multiple categories in FY 2013.

Table 4.14. Demographic Characteristics of Clients Receiving Home-based Case Management Services, FY 2013

Demographic Characteristic	Home-based Case Management (N=292)	
	N	%
Gender		
Male	229	78.4%
Female	60	20.5%
Transgender	<5	1.0%
Race/Ethnicity		
White	97	33.2%
African American	46	15.8%
Latino	141	48.3%
Asian Pacific Islander	7	2.4%
Native American	<5	0.3%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	<5	0.3%
19-24	<5	0.7%
25-29	<5	1.0%
30-39	26	8.9%
40-49	71	24.3%
≥ 50	189	64.7%
Primary Medical Insurance		
Private	31	10.6%
Public	169	57.9%
No Insurance	91	31.2%
Other	<5	0.3%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 4.15. Care Access and Health Outcomes of Clients Receiving Home-Based Case Management Services, FY 2013

Demographic Characteristic	Home-Based Case Management Services (N=292)	
	N	%
Receiving Ryan White (RW) Funded Medical Care	83	28.4%
New Client to RW System of Care	14	4.8%
Returning Client to RW System of Care	5	1.7%
Clients Accessed Any HIV Medical Care[o]	271	92.8%
Clients Retained in HIV Care*	239	81.8%
Clients with Viral Suppression**	213	72.9%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

4.10 Medical Nutrition Therapy

HRSA Definition: Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be reported under psychosocial support services.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Medical Nutrition Therapy provides assessment, interventions and treatment by registered dietitians to maintain and optimize nutrition status and self-management skills to help treat HIV disease through evaluation of nutritional needs and nutrition care planning, nutrition counseling, therapy and education. Services also include distributing nutritional supplements when appropriate; providing nutrition and HIV trainings to clients and their providers; and distributing nutrition-related educational materials to clients. Medical nutrition therapy is only funded as part of a one-stop shop medical model.

Funding Sources: Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$0	$27,104	$27,104

* Net County Cost - $27,104

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
59	Encounters	231

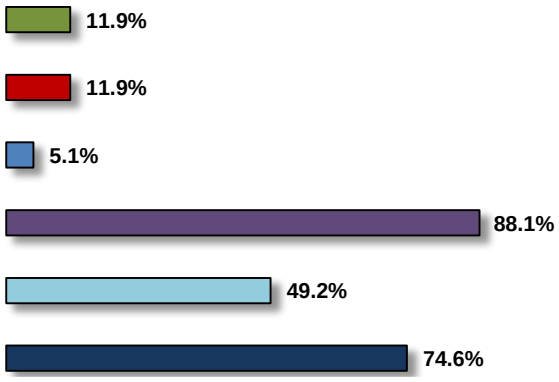
Table 4.16. Demographic Characteristics of Clients Receiving Medical Nutrition Therapy, FY 2013

Demographic Characteristic	Medical Nutritional Therapy (N=59) N	%
Gender		
Male	36	61.0%
Female	21	35.6%
Transgender	<5	3.4%
Race/Ethnicity		
White	9	15.3%
African American	34	57.6%
Latino	15	25.4%
Asian Pacific Islander	<5	1.7%
Native American	0	0.0%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	<5	1.7%
19-24	<5	5.1%
25-29	<5	6.8%
30-39	10	16.9%
40-49	17	28.8%
≥ 50	24	40.7%
Primary Medical Insurance		
Private	<5	1.7%
Public	49	83.1%
No Insurance	9	15.3%
Other	0	0.0%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 – February 2014)

Table 4.17. Care Access and Health Outcomes of Clients Receiving Medical Nutrition Therapy Services, FY 2013

Demographic Characteristic	Medical Nutrition Therapy Services (N=59)	
	N	%
Receiving Ryan White (RW) Funded Medical Care	7	11.9%
New Client to RW System of Care	7	11.9%
Returning Client to RW System of Care	<5	5.1%
Clients Accessed Any HIV Medical Care[o]	52	88.1%
Clients Retained in HIV Care*	29	49.2%
Clients with Viral Suppression**	44	74.6%



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

Chapter 5. Support Services

In FY 2013, DHSP funded the following list of support services for HIV/AIDS care and treatment:

10. Case Management, Non-Medical
11. Substance Abuse, Residential
12. Nutrition Support
13. Residential, Transitional
14. Medical Transportation
15. Language Services
16. Case Management, Transitional
17. Benefits Specialty
18. Legal Services

5.1 Case Management, Non-Medical

HRSA Definition: Case Management (Non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Commission Definition/Guidance: With the development of the standards of care for Medical Care Coordination (MCC), services that historically fall under Case Management, Non-Medical become part of MCC. MCC services include: outreach; intake; comprehensive assessment/reassessment; patient acuity assessment; comprehensive treatment plan; implementation and evaluation of comprehensive treatment plan; referral, coordination of care and linkages; case conferences; benefits specialty services; HIV prevention, education and counseling; and patient retention services.

What DHSP Funds: While clinic-based case management became part of MCC in FY 2013, some non-clinic-based case management services continued as Non-Medical Case Management the same year. The focus of these services is to connect clients to HIV medical homes in addition to provide advice and offer assistance in obtaining medical, social, community, legal, financial, and other needed services.

Funding Sources: RWP Part A and Net County Cost (NCC)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$1,012,091	$0	$64,813	$1,076,904

*NCC - $64,813

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
1,145	Case Management Hours	15,772

Table 5.1. Demographic Characteristics of Clients Receiving Non-Medical Case Management Services, FY 2013

Demographic Characteristics	Non-Medical Case Management (N=1,145) N	%
Gender		
Male	894	78.1%
Female	220	19.2%
Transgender	31	2.7%
Race/Ethnicity		
White	205	17.9%
African American	359	31.4%
Latino	523	45.7%
Asian Pacific Islander	53	4.6%
Native American	<5	0.3%
Other/Unknown	<5	0.2%
Age Categories		
≤18	8	0.7%
19-24	30	2.6%
25-29	75	6.6%
30-39	191	16.7%
40-49	379	33.1%
≥50	462	40.3%
Primary Medical Insurance		
Private	47	4.1%
Public	690	60.3%
No Insurance	400	34.9%
Other	8	0.7%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 5.2. Care Access and Health Outcomes of Clients Receiving Non-Medical Case Management Services, FY 2013

Demographic Characteristic	Non-Medical Case Management Services (N=1,145) N	%
Receiving Ryan White (RW) Funded Medical Care	336	29.3%
New Client to RW System of Care	71	6.2%
Returning Client to RW System of Care	28	2.4%
Clients Accessed Any HIV Medical Care°	1,027	89.7%
Clients Retained in HIV Care*	862	75.3%
Clients with Viral Suppression**	824	72.0%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
ºPatients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.2 Substance Abuse, Residential

HRSA Definition: Substance Abuse Services (Residential) is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Commission Definition/Guidance: Substance Abuse, Residential, includes residential rehabilitation and transitional housing services that assist clients achieve and maintain a lifestyle free of substance abuse and to transition to permanent, stable housing. *Substance abuse residential rehabilitation services* provide 24-hour, residential *non-medical* services to individuals recovering from problems related to alcohol and/or drug abuse and who need alcohol and/or drug abuse treatment or detoxification services. *Substance abuse transitional housing services* provide interim housing with supportive services for up to four months for recently homeless persons living with HIV in various stages of recovery from substance abuse. The purpose of the service is to facilitate continued recovery from substance abuse and movement toward more traditional, permanent housing through assessment of the individual's needs, counseling and case management.

What DHSP Funds: Substance Abuse Residential Services provided under contract with DHSP include substance abuse residential rehabilitation and substance abuse transitional housing. Residential detoxification services are reported here due to HRSA service definitions.

HIV/AIDS Substance Abuse Residential Rehabilitation Services provide 24 hour, residential, non-medical services to individuals who are recovering from problems related to alcohol and/or other drug abuse and who need alcohol and/or other drug abuse treatment. The purpose of this service is to assist individuals to achieve and maintain a life style free of substance abuse. Clients are assessed for the appropriate intensity level of service which dictates the duration of service as well: High intensity (8 weeks); Medium intensity (12 weeks); and Low intensity (16 weeks).

HIV/AIDS Substance Abuse Transitional Housing Services provides interim housing with supportive services for up to four months that are exclusively designated and targeted for recently homeless persons living with HIV/AIDS in various stages of recovery from substance abuse. The purpose of the service is to facilitate continued recovery from substance abuse and movement toward more traditional, permanent housing through assessment of the individual's needs, counseling and case management.

HIV/AIDS Substance Abuse Residential Detoxification Programs must be licensed and approved by the State of California Department of Health Services as a Chemical Dependency Recovery Hospital and operate in accordance with Chapter 11, Title 22 of the California Code of Regulations. The maximum length of stay for substance abuse residential detoxification services is 14 days, although extensions can be granted under special circumstances with a physician's order. Services include: initial screening; client intake; client assessment; treatment

planning; providing medication prescribed by a medical professional; crisis intervention; counseling; support groups; education; and treatment linkages and referral.

Funding Sources: RWP Part B, and State (pass-through from SAMSHA Center for Substance Abuse Treatment/Center for Substance Abuse Prevention - CSAT)

Expenditures and Funding Sources: RWP Part B and State (pass-through) CSAT

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$1,139,250	$130,967	$1,270,217

*State CSAT = $130,967 (detox only)

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
412 (Residential Clients)	Residential Days	23,849

Table 5.3. Demographic Characteristics of Clients Receiving Substance Abuse Residential Services, FY 2013

	Substance Abuse Residential Services (N=412)	
	N	**%**
Gender		
Male	370	89.8%
Female	37	9.0%
Transgender	5	1.2%
Race/Ethnicity		
White	147	35.7%
African American	136	33.0%
Latino	118	28.6%
Asian Pacific Islander	5	1.2%
Native American	<5	1.0%
Other/Unknown	<5	0.5%
Age Categories		
≤ 18	0	0.0%
19-24	27	6.6%
25-29	54	13.1%
30-39	126	30.6%
40-49	131	31.8%
≥ 50	74	18.0%
Primary Medical Insurance		
Private	<5	0.7%
Public	292	70.9%
No Insurance	117	28.4%
Other	0	0.0%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 5.4. Care Access and Health Outcomes of Clients Receiving Substance Abuse Residential Services, FY 2013

Demographic Characteristic	Substance Abuse Residential Services (N=412)	
	N	%
Receiving Ryan White (RW) Funded Medical Care	123	29.9%
New Client to RW System of Care	48	11.7%
Returning Client to RW System of Care	26	6.3%
Clients Accessed Any HIV Medical Care°	389	94.4%
Clients Retained in HIV Care*	279	67.7%
Clients with Viral Suppression**	244	59.2%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
°Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.3 Nutrition Support

HRSA Definition: Food Bank/Home-Delivered Meals are the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies also should be included in this item. It does not include financial assistance or meals.

Commission Definition/Guidance: Nutrition Support includes the provision of actual food or meals. It does not include funds to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this service definition. Nutrition Support also includes vouchers to purchase food.

What DHSP Funds: Nutrition Support Services provided under contract with DHSP include home delivered meals and food banks/pantry services. Home delivered meals are provided for clients experiencing physical or emotional difficulties related to HV/AIDS that render them incapable of consistently preparing meals for themselves. These services are offered to medically indigent (uninsured and/or ineligible for health care coverage) persons with HIV/AIDS and their eligible family members residing within Los Angeles County. Food bank/pantry services are distribution centers that warehouse food and related grocery items.

Funding Sources: RWP Part A

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other	Total
Expenditures	$683,826	0	0	$683,826

Service Utilization:

Total Clients Served*	Service Units	Units of Service Provided
1,949	Bagged groceries	18,313
330	Home delivered meals	80,313

*The total unduplicated number of clients receiving services from both service types was 2,174.

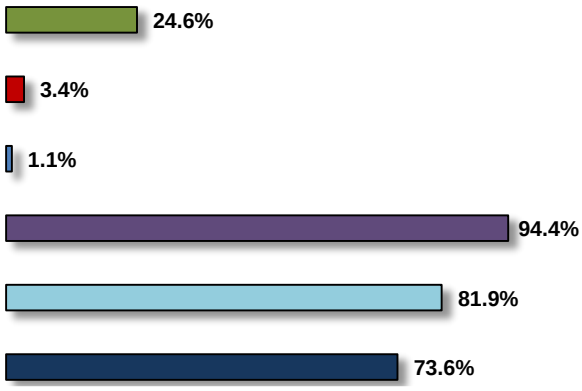
Table 5.5. Demographic Characteristics of Clients Receiving Nutrition Support Services, FY 2013

	Nutrition Support (N=2,174)*	
	N	%
Gender		
Male	1,793	82.5%
Female	325	14.9%
Transgender	56	2.6%
Other/Unknown	0	0.0%
Race/Ethnicity		
White	442	20.3%
African American	674	31.0%
Latino	998	45.9%
Asian Pacific Islander	46	2.1%
Native American	12	0.6%
Other/Unknown	<5	0.1%
Age Categories		
≤ 18	<5	0.1%
19-24	21	1.0%
25-29	47	2.2%
30-39	222	10.2%
40-49	702	32.3%
≥ 50	1,179	54.2%
Primary Medical Insurance		
Private	54	2.5%
Public	1,585	72.9%
No Insurance	519	23.9%
Other	14	0.6%
Unknown	<5	0.1%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)
*It is possible for clients to receive both type of services within one year.

Table 5.6. Care Access and Health Outcomes of Clients Receiving Nutrition Support Services, FY 2013

Demographic Characteristic	Nutrition Support Services (N=2,174) N	%
Receiving Ryan White (RW) Funded Medical Care	534	24.6%
New Client to RW System of Care	74	3.4%
Returning Client to RW System of Care	23	1.1%
Clients Accessed Any HIV Medical Care[o]	2,052	94.4%
Clients Retained in HIV Care*	1,780	81.9%
Clients with Viral Suppression**	1,600	73.6%



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.4 Residential Services

HRSA Definition: Housing Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Commission Definition/Guidance: As part of the Residential Care and Housing cluster, Residential, Transitional services include Transitional Residential Care Facilities (TRCF) and Residential Care Facilities for the Chronically Ill (RCFCI). Services include the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services. Includes emergency shelter, transitional housing, Adult Residential Facility and Residential Care Facility for the Chronically Ill.

What DHSP Funds: DHSP only funds Residential Care Services and not Housing Services. Residential Care Services under contract with DHSP include:

Transitional Residential Care Facilities (TRCF): TRCFs provide interim housing with ongoing supervision and assistance with Independent Living Skills (ILS) for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management, and other supportive services.

Residential Care Facilities for the Chronically Ill (RCFCI): Any housing arrangement maintained and operated to provide licensed care and supervision to adults, emancipated minors or family units living with HIV. An RCFCI may not exceed 50 beds.

Funding Sources: RWP Part B and Net County Cost (NCC)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$1,139,250	$2,849,468	$3,988,718

*NCC = $2,849,468

Table 5.7. Demographic Characteristics of Clients Receiving Residential Services, FY 2013

	Residential Transitional Services (N=156)	
	N	**%**
Gender		
Male	108	69.2%
Female	46	29.5%
Transgender	<5	<1%
Race/Ethnicity		
White	0	0.0%
African American	45	28.8%
Latino	79	50.6%
Asian Pacific Islander	<5	<1%
Native American	<5	<1%
Other/Unknown	29	18.6%
Age Categories		
≤ 18	0	0.0%
19-24	8	5.1%
25-29	11	7.1%
30-39	27	17.3%
40-49	46	29.5%
≥ 50	64	41.0%
Primary Medical Insurance		
Private	<5	1.9%
Public	97	62.2%
No Insurance	56	35.9%
Other	0	0.0%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided	
40	Residential Days	Transitional Residential Care Facilities (TRCF)	6,398
119		Residential Care Facilities for the Chronically Ill (RCFCI)	24,550

Note: It is possible for a client to receive both types of Residential Services (TRCF and RCFCI) in a given year. The number of total unduplicated, unique clients in FY 2013 was 156.

Table 5.8. Care Access and Health Outcomes of Clients Receiving Residential Care Services, FY 2013

Demographic Characteristic	Residential Care Services (N=156) N	%
Receiving Ryan White (RW) Funded Medical Care*	47	30.1%
New Client to RW System of Care	12	7.7%
Returning Client to RW System of Care	7	4.5%
Clients Accessed Any HIV Medical Care**	143	91.7%
Clients Retained in HIV Care*	129	82.7%
Clients with Viral Suppression**	115	73.7%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
ºPatients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.5 Medical Transportation

HRSA Definition: Medical Transportation Services include conveyance services provided, directly or through vouchers, to a client so that he or she may access health care services. This service definition does not preclude grantees from providing transportation for clients who need assistance to get to a support service appointment.

Commission Definition/Guidance: Medical Transportation includes conveyance services provided, directly or through voucher including taxi vouchers, bus passes and bus tokens, to a client so that s/he may access health care services,. HIV transportation services are provided to medically indigent clients living with HIV and their immediate families for the purpose of providing transportation to medical and social services appointments. Transportation services are not provided for recreational and/or entertainment purposes.

What DHSP Funds: Transportation Services in Los Angeles County include: taxi services; public transit services (bus tokens, bus passes and MetroLink tickets) and disabled ID cards.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$592,140	$0	$1,321	$593,461

*NCC expenditures - $1,321

Service Utilization:

Services	Total Clients Served	Service Unit	Service Units Provided
Taxi service	835	Taxi rides	2,080
Bus passes	2,606	Number of monthly passes	23,631
MetroLink	14	Train rides	22
Bus tokens	310	Bus tokens	4,979
Disabled ID cards	113	Number of ID cards	113
Van Services	77	Van Rides	2,369

5.6 Language Services

HRSA Definition: Linguistics Services include the provision of interpretation and translation services.

***Commission Definition/Guidance*:** Language Services are part of the Los Angeles County Commission Retention in Care Services cluster. They are designed to provide language and sign language interpretation services for limited English proficiency (LEP) people living with HIV and their immediate families, who require special assistance in accessing HIV/AIDS services. Language interpretation services must be provided by a qualified interpreter who is able to communicate fluently in both English and the native language of the client. Sign language provided for deaf and/or hard of hearing people living with HIV must be provided by a qualified interpreter who is fluent in American Sign Language. Services include the provision of interpretation and translation services. Services include healthcare interpretation training, language translation, and American Sign Language interpretation.

What DHSP Funds: Language Services provided under contract with DHSP consist of health care interpretation training, healthcare interpreter re-certification, (document) translation services, and American Sign Language interpretation.
Funding Sources: Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	0	0	$215,739	$215,739

*NCC expenditures - $215,739

Service Utilization:

Services	Clients Served	Service Units	Service Units Provided
Sign language interpretation	11	Sign interpretation hours	152
Interpreter training	N/A	Interpreter training hours	120
Translation services	N/A	Translated words	111,063
Direct interpretation services	59	Direct interpretation hours	593

*The total unduplicated clients include only clients receiving sign language interpretation and direct interpretation services, and do not include clients receiving interpreter training.

5.7 Case Management, Transitional

HRSA Definition: HRSA does not have a specific category for Case Management, Transitional. The service falls under the category Case Management (Non-Medical).

Commission Definition/Guidance: HIV Case Management, Transitional Services are part of the Los Angeles County Commission cluster of Linkage to Care. They encompass two distinct and varied populations – persons making the transition from incarceration to mainstream HIV services; and youth, especially those who are runaways, homeless and emancipating/emancipated. HIV case management, transitional services are client-centered activities through which care for special transitional populations living with HIV is coordinated.

What DHSP Funds: Case Management, Transitional (TCM) Services provided under contract can include: intake and assessment of available resources and needs; development and implementation of individual release plans or transitional independent living plans; coordination of services; interventions on behalf of the client or family; linked referrals; active, ongoing monitoring and follow-up; and periodic assessment of status and needs. The goals of TCM services for incarcerated and post-incarcerated people living with HIV include: reducing re-incarceration; improving the health status of incarcerated or recently released inmates; easing a client's transition from incarceration to community care; increasing self-efficacy; facilitating access and adherence to primary health care; ensuring access to appropriate services and to the continuum of care; increasing access to HIV information and education; and developing resources and increasing coordination between providers.

For homeless, runaway and emancipating/emancipated youth living with HIV, the goals of TCM services include: reducing homelessness; reducing substance use/abuse; improving the health status of transitional youth; easing a youth's transition from living on the streets or in foster care to community care; increasing access to education; increasing self-efficacy and self-sufficiency; facilitating access and adherence to primary health care; ensuring access to appropriate

services and to the continuum of care; increasing access to HIV information and education; and developing resources and increasing coordination between providers.

Funding Sources: RWP Part B, MAI, and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$0	$492,400	$150,491	$642,891

* MAI expenditures - $145,576; NCC expenditures - $4,915

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
1,078 – incarcerated	Hours	6,882
139 – youth	Hours	2,590

Table 5.9. Demographic Characteristics of *Incarcerated* Clients Receiving Transitional Case Management Services, FY 2013

Demographic Characteristics	Transitional Case Management for Incarcerated Individuals (N=1,078)	
	N	%
Gender		
Male	979	90.8%
Female	82	7.6%
Transgender	17	1.6%
Race/Ethnicity		
White	250	23.2%
African American	527	48.9%
Latino	275	25.5%
Asian Pacific Islander	14	1.3%
Native American	7	0.6%
Other/Unknown	5	0.5%
Age Categories		
≤18	0	0.0%
19-24	74	6.9%
25-29	144	13.4%
30-39	293	27.2%
40-49	336	31.2%
≥50	231	21.4%
Primary Medical Insurance		
Private	14	1.3%
Public	513	47.6%
No Insurance	474	44.0%
Other	11	1.0%
Unknown	66	6.1%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 5.10. Demographic Characteristics of *Youth* Clients Receiving Transitional Case Management Services, FY 2013

Demographic Characteristics	Transitional Case Management for Youth (N=139)	
	N	%
Gender		
Male	119	85.6%
Female	17	12.2%
Transgender	<5	2.2%
Race/Ethnicity		
White	13	9.4%
African American	46	33.1%
Latino	74	53.2%
Asian Pacific Islander	5	3.6%
Native American	0	0.0%
Other/Unknown	<5	0.7%
Age Categories		
≤18	12	8.6%
19-24	115	82.7%
25-29	12	8.6%
Unknown	0	0.0%
Primary Medical Insurance		
Private	13	9.4%
Public	73	52.5%
No Insurance	53	38.1%
Other	0	0.8%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 5.11. Care Access and Health Outcomes of *Incarcerated* Clients Receiving Transitional Case Management Services, FY 2013

Demographic Characteristic	Transitional Case Management, Incarcerated (N=1,087)	
	N	%
Receiving Ryan White (RW) Funded Medical Care	177	16.4%
New Client to RW System of Care	44	4.1%
Returning Client to RW System of Care	26	2.4%
Clients Accessed Any HIV Medical Care°	949	87.3%
Clients Retained in HIV Care*	518	47.7%
Clients with Viral Suppression**	399	36.7%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
Note: See footnote next page (Table 5.12) for definitions for clients accessed and retained HIV care and achieved viral suppression.

Table 5.12. Care Access and Health Outcomes of *Youth* Clients Receiving Transitional Case Management Services, FY 2013

Demographic Characteristic	Transitional Case Management, Youth (N=139)	
	N	%
Receiving Ryan White (RW) Funded Medical Care	66	47.5%
New Client to RW System of Care	42	30.2%
Returning Client to RW System of Care	5	3.6%
Clients Accessed Any HIV Medical Care[o]	126	90.6%
Clients Retained in HIV Care*	93	66.9%
Clients with Viral Suppression**	84	60.4%

Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
[o]Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013. *Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart. **Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.8 Benefits Specialty

HRSA Definition: HRSA does not have a specific category for Benefits Specialty. The service falls under the category Case Management, Non-Medical.

Commission Definition/Guidance: Benefits Specialty Services facilitate a client's access to public/private health and disability benefits and programs. Benefits Specialty Services work to maximize public funding by assisting clients to identify all available health and disability benefits supported by funding streams other than RWP Part A funds. Benefits Specialty Services facilitate a client's entry into and movement through the care service delivery network. Benefits Specialty Services are designed to educate people living with HIV about public and private benefits and entitlement programs and to provide assistance in accessing and securing these benefits.

What DHSP Funds: Benefits Specialty Services can include assessment of benefit need and eligibility, assistance with completing benefits paperwork, appeals counseling and facilitation, and assistance and management of benefits issues for clients who are enrolled in health and disability programs.

Funding Sources: RWP Part A and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other	Total
Expenditures	$649,222	$0	$22,288	$671,510

* NCC expenditures - $22,288

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
2,969	Benefits Specialty Counseling Hour	13,506

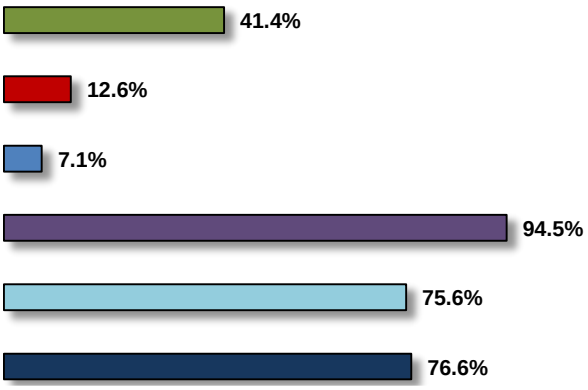
Table 5.12. Demographic Characteristics of Clients Receiving Benefits Specialty Services, FY 2013

Demographic Characteristics	Benefits Specialty (N=2,969) N	%
Gender		
Male	2,599	87.5%
Female	331	11.1%
Transgender	39	1.3%
Race/Ethnicity		
White	847	28.5%
African American	592	19.9%
Latino	1,410	47.5%
Asian Pacific Islander	107	3.6%
Native American	9	0.3%
Other/Unknown	<5	0.1%
Age Categories		
≤18	7	0.2%
19-24	72	2.4%
25-29	188	6.3%
30-39	569	19.2%
40-49	975	32.8%
≥50	1,158	39.0%
Primary Medical Insurance		
Private	382	12.9%
Public	1,582	53.3%
No Insurance	986	33.2%
Other	19	0.6%
Unknown	0	0.0%

Data Source: Casewatch FY 2013 (March 2013 - February 2014)

Table 5.13. Care Access and Health Outcomes of Clients Receiving Benefits Specialty Services, FY 2013

Demographic Characteristic	Benefits Specialty Services (N=2,969) N	%
Receiving Ryan White (RW) Funded Medical Care	1,230	41.4%
New Client to RW System of Care	373	12.6%
Returning Client to RW System of Care	212	7.1%
Clients Accessed Any HIV Medical Care°	2,805	94.5%
Clients Retained in HIV Care*	2,244	75.6%
Clients with Viral Suppression**	2,275	76.6%



Data Source: Casewatch and iHARS data (March 1, 2013 – February 28, 2014) as of January 1, 2015.
°Patients living with HIV and who had at least one "marker of care," defined as having ≥1 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visit paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013.
*Defined as patients who have ≥ 2 viral load, CD4+ T-cell, genotyping tests reported in HIV surveillance data, or medical visits paid by Ryan White Ambulatory Outpatient Medical Care, during FY 2013, at least 3 months apart.
**Viral suppression is defined as having a most recent viral load ≤ 200 copies/ml during FY 2013.

5.9 Legal Services

HRSA Definition: Legal Services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWP. It does not include any legal services that arrange for guardianship or adoption of children after the death of their caregiver.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Legal Services funded by DHSP are services that resolve HIV-related legal services for individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWP. HIV Legal Services do not include guardianship or adoption of children after the death of their legal caregiver, criminal defense, discrimination or class action litigation unrelated to RWP services.

Funding Sources: RW Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B	Other*	Total
Expenditures	$68,885	$0	$22,500	$91,385

*NCC expenditures - $22,500

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
76	Legal Service Hour	1,233
	Legal Forum	5
	Provider information Session	4

Appendix

Table A.1. FY 2013 Ryan White Part A, Part B and MAI Final Allocations

SERVICE CATEGORY	REVISED FY 2013 ALLOCATION % *PART A & Part B*	REVISED FY 2013 ALLOCATION % *MAI*
AMBULATORY OUTPATIENT MEDICAL	**46.6**	**-**
BENEFITS SUPPORT	2.5	-
ORAL HEALTH CARE	**9.3**	**30.0**
MENTAL HEALTH, PSYCHIATRY	**2.9**	**-**
MENTAL HEALTH, PSYCHOTHERAPY	**5.3**	**-**
MEDICAL CARE COORDINATION	**11.5**	**45.0**
CASE MANAGEMENT, NON-MEDICAL	7.1	-
LINKAGE TO CARE (LTC)	-	-
HEALTH INSURANCE PREMIUMS	-	-
SUBSTANCE ABUSE, RESIDENTIAL SERVICES	4.1	-
RESIDENTIAL CARE/HOUSING SERVICES	-	-
MEDICAL TRANSPORTATION	1.7	-
NUTRITION SUPPORT	1.0	-
TRANSITIONAL CASE MANAGEMENT (TCM)	1.2	25.0
LONG TERM AND PALLIATIVE CARE (LTPC)	-	-
HOME-BASED CASE MANAGEMENT	**6.8**	**-**
VISION CARE		
MEDICAL NUTRITION THERAPY	-	-
LEGAL SERVICES	-	-
LANGUAGE SERVICES	-	-
SUB-TOTAL DIRECT SERVICES*	**100.0**	**100.0**

Table A.1a. Ryan White Service Categories Used by Los Angeles County Division of HIV and STD Programs, Cross-Referenced with Commission ON HIV Service Categories

	SERVICES for HIV Positive Individuals as Defined by HRSA		COH Service Categories
1	Outpatient/Ambulatory Medical Care	1	Ambulatory Outpatient
		2	Medical Services
		3	Medical Subspecialty Services
		4	Therapeutic Monitoring Program
2	Local AIDS Pharmaceutical Assistance	5	Local AIDS Pharmaceutical Assistance
3	Oral Health Care	6	Oral Health Care
4	Early Intervention Services		
5	Health Insurance Premium and Cost-Sharing Assistance	7	Health Insurance Premium and Cost-Sharing Assistance
6	Home Health Care	8	Home Health Care
7	Home and Community-Based Health Services	9	Home Based Care Management
8	Hospice Services	10	Hospice Services
9	Mental Health Services	11	MH, Psychiatry
		12	MH, Psychotherapy
10	Medical Nurition Therapy	13	Medical Nurition Therapy
11	Medical Case Management Services	14	Medical Care Coordination
12	Substance Abuse Treatment Services - Outpatient	15	Substance Abuse Treatment - Day Treatment
13	CaseManagement Services (non-Medical)	16	Linkage Case Management
		17	Benefits Specialty
		18	Benefits Navigation
		19	Transitional Case Management
		20	House Case Management
14	Child Care Services	21	Child Care
15	Pediatric Develpmental Assessment and Early Intervention Services	22	See Limitations

	SERVICES for HIV Positive Individuals as Defined by HRSA		COH Service Categories
16	Emeregency Financial Assistance	23	Direct Emergency Financial Assistance
		24	Hotel/Motel/Meal Vouchers
17	Food Bank/Home-Delivered Meals	25	Nutrition Support
18	Health Education/Risk Reduction	26	Health Education/Risk Reduction
19	Housing Services	27	Residential Care Facilities for the Chronically ill
		28	Transitional Residential Care Facilities
		29	Emergency Shelters
		30	Transitional Housing
		31	Permanent Support Housing
20	Legal Services	32	Legal Services
21	Linguistics Services	33	Language/Interpretation Services
22	Medical Transportation Services	34	Medical Transportation
23	Outreach Services	35	Outreach Services
24	Permanency Planning	36	Not a COH Service
25	Psychosocial Support Services	37	Psychosocial Support Services
26	Referral for Health Care/Support Services	38	Referrals
27	Rehabilitation Services	39	Rehabilitation Services
28	Respite Care	40	Respite Care
29	Substance Abuse Treatment Services-Residential	41	Substance Abuse Treatment Residential Detoxification
30	Treatment Adherence Counseling	42	Treatment Education

Note: the table is extracted from a draft prepared by Los Angeles County Commission on HIV and the Division of HIV and STD Programs, April 21, 2015.

Table A.2. Persons Living with an HIV Infection as of December 31, 2013, by Race/Ethnicity, Gender, Age, Transmission Category, and Service Planning Area Reported by December 31, 2013, Los Angeles County

	White			Black			Hispanic/Latino			Other (2)			Total (3)		
	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female	All
	No. (%)	No.(%)	No. (%)	No. (%)	No.(%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
AGE GROUP (4)															
<13	<5(-)	5(1)	6(<1)	8(<1)	6(<1)	14(<1)	<5(-)	7(<1)	11(<1)	<5(-)	<5(-)	<5(-)	16(<1)	20(<1)	36(<1)
13-19	8(<1)	<5(-)	9(<1)	28(<1)	24(1)	52(1)	56(<1)	32(1)	88(<1)	<5(-)	<5(-)	<5(-)	96(<1)	58(1)	154(<1)
20-29	524(4)	41(5)	565(4)	976(13)	157(8)	1133(12)	1587(9)	228(10)	1815(9)	153(9)	11(6)	164(9)	3309(8)	441(8)	3750(8)
30-39	1575(11)	98(12)	1673(11)	1245(16)	337(18)	1582(17)	3964(23)	556(23)	4520(23)	375(23)	41(23)	416(23)	7266(17)	1046(20)	8312(18)
40-49	4343(29)	258(32)	4601(30)	2153(28)	592(31)	2745(29)	6108(36)	733(31)	6841(35)	555(34)	53(29)	608(33)	13333(32)	1662(31)	14995(32)
50-59	5661(38)	250(31)	5911(38)	2301(30)	564(30)	2865(30)	4028(23)	553(23)	4581(23)	387(24)	45(25)	432(24)	12563(30)	1426(27)	13989(30)
60+	2660(18)	145(18)	2805(18)	940(12)	216(11)	1156(12)	1394(8)	289(12)	1683(9)	167(10)	30(17)	197(11)	5223(12)	689(13)	5912(13)
TRANSMISSION CATEGORY (5)															
MSM	13138(89)	-(-)	13138(84)	6235(81)	-(-)	6235(65)	15014(88)	-(-)	15014(77)	1484(90)	-(-)	1484(81)	36362(87)	-(-)	36362(77)
IDU	344(2)	298(37)	642(4)	432(6)	448(24)	881(9)	542(3)	331(14)	873(4)	26(2)	24(13)	50(3)	1368(3)	1125(21)	2493(5)
MSM/IDU	1153(8)	-(-)	1153(7)	659(9)	-(-)	659(7)	976(6)	-(-)	976(5)	87(5)	-(-)	87(5)	2946(7)	-(-)	2946(6)
Hemophi/Transfusion	27(<1)	10(1)	37(<1)	12(<1)	18(1)	30(<1)	36(<1)	23(1)	59(<1)	8(<1)	<5(-)	10(1)	84(<1)	55(1)	139(<1)
Heterosexual contact	92(1)	478(60)	570(4)	264(3)	1383(73)	1647(17)	508(3)	1964(82)	2472(13)	31(2)	154(85)	185(10)	907(2)	4020(75)	4926(10)
Perinatal exposure	18(<1)	10(1)	28(<1)	46(1)	46(2)	92(1)	61(<1)	76(3)	137(1)	7(<1)	<5(-)	8(<1)	133(<1)	135(3)	268(1)
Other/Undetermined	<5(-)	<5(-)	<5(-)	<5(-)	<5(-)	<5(-)	<5(-)	<5(-)	8(<1)	<5(-)	<5(-)	<5(-)	7(<1)	7(<1)	14(<1)
SERVICE PLANNING AREA															
Antelope Valley[1]	165(1)	35(4)	200(1)	145(2)	63(3)	208(2)	175(1)	45(2)	220(1)	8(<1)	<5(-)	12(1)	503(1)	151(3)	654(1)
San Fernando[2]	2533(17)	201(25)	2734(18)	659(9)	158(8)	817(9)	2364(14)	320(13)	2684(14)	253(15)	22(12)	275(15)	5902(14)	707(13)	6609(14)
San Gabriel[3]	646(4)	75(9)	721(5)	307(4)	102(5)	409(4)	1555(9)	240(10)	1795(9)	256(16)	40(22)	296(16)	2804(7)	459(9)	3263(7)
Metro[4]	6948(47)	172(22)	7120(46)	2522(33)	332(18)	2854(30)	6432(38)	596(25)	7028(36)	608(37)	44(24)	652(36)	16745(40)	1160(22)	17905(38)
West[5]	1362(9)	89(11)	1451(9)	331(4)	73(4)	404(4)	523(3)	48(2)	571(3)	103(6)	13(7)	116(6)	2360(6)	227(4)	2587(5)
South[6]	138(1)	24(3)	162(1)	1879(25)	607(32)	2486(26)	1746(10)	470(20)	2216(11)	31(2)	9(5)	40(2)	3843(9)	1127(21)	4970(11)
East[7]	336(2)	38(5)	374(2)	143(2)	59(3)	202(2)	2019(12)	355(15)	2374(12)	86(5)	12(7)	98(5)	2600(6)	467(9)	3067(7)
South Bay/LB[8]	2558(17)	157(20)	2715(17)	1626(21)	490(26)	2116(22)	2253(13)	318(13)	2571(13)	289(18)	37(20)	326(18)	6838(16)	1019(19)	7857(17)
Total (6)	14772[95]	798[5]	15570[100]	7651[80]	1896[20]	9547[100]	17141[88]	2398[12]	19539[100]	1643[90]	181[10]	1824[100]	41806[89]	5342[11]	47148[100]

1. Data are provisional due to reporting delay.
2. Other includes Asian, Pacific Islander, American Indian and Alaskan Native.
3. Total includes persons who have multiple races/ethnicities or have missing information on race/ethnicity.
4. Age as of December 31, 2013.
5. Persons without an identified risk factor are assigned a risk factor using multiple imputation (MI) methods (see Technical Notes).
6. Total includes persons who have missing information on SPA. Percent of total cases that are male and female is shown in this row.

Data Source: Division of HIV and STD Programs. *County of Los Angeles Department of Public Health 2013 Annual HIV Surveillance Report*. April 2014.

Table A.3. Demographic Characteristics of All Ryan White Program Clients and Clients in Medical Care, FY 2013

Characteristic	All RW Clients		RW Clients AOM	
	n	%	n	%
New Client[1]	1,864	10.3	1,003	10.7
Returning Client[2]	716	3.9	272	2.9
Gender				
Female	2,119	11.7	924	9.9
Male	15,710	86.6	8,277	88.4
Transgender	305	1.7	166	1.8
Other/Unknown	0	0.0	0	0.0
Race/Ethnicity				
African-American	3,995	22.0	1,325	14.1
Asian/Pacific-Islander	673	3.7	386	4.1
Latino/Hispanic	9,018	49.7	5,868	62.6
Native American/Alaskan Native	56	0.3	17	0.2
Other/Unknown	23	0.1	3	0.0
White/Caucasian	4,369	24.1	1,768	18.9
Age				
0-18	51	0.3	12	0.1
19-24	718	4.0	351	3.7
25-29	1,493	8.2	892	9.5
30-39	3,966	21.9	2,540	27.1
40-49	6,062	33.4	3,416	36.5
≥50	5,844	32.2	2,156	23.0
HIV/AIDS Status				
CDC Defined AIDS	8,554	47.2	4,158	44.4
HIV+, Not AIDS	6,761	37.3	1,492	15.9
HIV+, AIDS Status Unknown	2,804	15.5	3,717	39.7
HIV Negative (High Risk/affected)	4	0.0	0	0.0
Unknown	11	0.1	0	0.0
Primary Insurance				
No Insurance	8,638	47.6	7,235	77.2
Other	83	0.5	21	0.2
Private	1,123	6.2	364	3.9
Public	8,222	45.3	1,747	18.7
Unknown	68	0.4	0	0.0
Income Level				
101-200% of FPL	4,150	22.9	2,366	25.3

Characteristic	All RW Clients		RW Clients AOM	
201-300% of FPL	1,214	6.7	848	9.1
301-400% of FPL	486	2.7	323	3.4
> 400% FPL	105	0.6	50	0.5
≤ Federal Poverty Level	12,179	67.2	5,780	61.7
Unknown	0	0.0	0	0.0
Living Situation				
Institution (residential/health care/correctional)	900	5.0	212	2.3
Homeless/Transitional	1,115	6.1	378	4.0
Other	1	0.0	0	0.0
Permanent	15,532	85.7	8,551	91.3
Unknown	586	3.2	226	2.4
Incarceration History				
Incarcerated > 2 yrs.	1,690	9.3	559	6.0
Incarcerated ≤ 24 mo.	2,306	12.7	783	8.4
Never Incarcerated	14,064	77.6	8,025	85.7
Unknown	74	0.4	0	0.0
TOTAL	**18,134**	**100.0%**	**9,367**	**100.0%**

Data Source: Casewatch FY 2013 (March 2013 - February 2014).

1. New client refers to a client who entered the care system for the first time during FY 2013.
2. Returning client refers to a client who returned to the care system during FY 2013 after not having accessed services in the last 12 months.

Table A.4. Demographic Characteristics of All Clients by Residence Service Planning Area (SPA), FY 2013

	SPA 1		SPA 2		SPA 3		SPA 4		SPA 5		SPA 6		SPA 7		SPA 8		Unknown SPA	
Characteristic	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
New Client	27	8.3%	244	9.3%	136	10.2%	603	9.5%	116	18.2%	227	8.9%	146	10.6%	252	9.6%	113	38.6%
Returning Client	18	5.6%	80	3.0%	67	5.0%	170	2.7%	36	5.6%	91	3.6%	77	5.6%	165	6.3%	12	4.1%
Gender																		
Female	84	25.9%	321	12.2%	176	13.3%	404	6.3%	62	9.7%	507	19.9%	188	13.7%	341	12.9%	36	12.3%
Male	238	73.5%	2,257	85.8%	1,136	85.6%	5,825	91.5%	574	89.8%	1,999	78.6%	1,173	85.4%	2,255	85.6%	253	86.3%
Transgender	2	0.6%	54	2.1%	15	1.1%	138	2.2%	3	0.5%	37	1.5%	13	0.9%	39	1.5%	4	1.4%
Race/Ethnicity																		
African-American	128	39.5%	391	14.9%	169	12.7%	1,054	16.6%	111	17.4%	1,233	48.5%	86	6.3%	737	28.0%	86	29.4%
Asian/Pacific-Islander	7	2.2%	104	4.0%	123	9.3%	234	3.7%	38	5.9%	17	0.7%	35	2.5%	107	4.1%	8	2.7%
Latino/Hispanic	130	40.1%	1,400	53.2%	793	59.8%	3,042	47.8%	197	30.8%	1,155	45.4%	1,097	79.8%	1,096	41.6%	108	36.9%
Native American/Alaskan Native	3	0.9%	5	0.2%	7	0.5%	19	0.3%	0	0.0%	4	0.2%	4	0.3%	14	0.5%	0	0.0%
Other/Unknown	0	0.0%	1	0.0%	0	0.0%	10	0.2%	1	0.2%	2	0.1%	0	0.0%	5	0.2%	4	1.4%
White/Caucasian	56	17.3%	731	27.8%	235	17.7%	2008	31.5%	292	45.7%	132	5.2%	152	11.1%	676	25.7%	87	29.7%
Age																		
0-18	1	0.3%	8	0.3%	3	0.2%	9	0.1%	0	0.0%	16	0.6%	3	0.2%	10	0.4%	1	0.3%
19-24	16	4.9%	82	3.1%	53	4.0%	220	3.5%	19	3.0%	128	5.0%	51	3.7%	126	4.8%	23	7.8%
25-29	19	5.9%	198	7.5%	108	8.1%	494	7.8%	47	7.4%	257	10.1%	106	7.7%	215	8.2%	49	16.7%
30-39	47	14.5%	628	23.9%	299	22.5%	1,437	22.6%	134	21.0%	520	20.4%	326	23.7%	491	18.6%	84	28.7%
40-49	122	37.7%	901	34.2%	426	32.1%	2,220	34.9%	191	29.9%	779	30.6%	473	34.4%	865	32.8%	85	29.0%
50+	119	36.7%	815	31.0%	438	33.0%	1,987	31.2%	248	38.8%	843	33.1%	415	30.2%	928	35.2%	51	17.4%
Primary Insurance																		
No Insurance	100	30.9%	1,303	49.5%	622	46.9%	3,112	48.9%	319	49.9%	1,226	48.2%	768	55.9%	1,066	40.5%	122	41.6%
Other	0	0.0%	9	0.3%	4	0.3%	30	0.5%	5	0.8%	18	0.7%	4	0.3%	12	0.5%	1	0.3%
Private	12	3.7%	210	8.0%	81	6.1%	409	6.4%	49	7.7%	74	2.9%	83	6.0%	187	7.1%	18	6.1%
Public	212	65.4%	1,110	42.2%	620	46.7%	2,816	44.2%	266	41.6%	1,225	48.2%	519	37.8%	1,370	52.0%	84	28.7%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	68	23.2%
Homeless	19	5.9%	123	4.7%	83	6.3%	459	7.2%	59	9.2%	147	5.8%	62	4.5%	148	5.6%	15	5.1%
In Medical Care (AOM)	95	29.3%	1,551	58.9%	701	52.8%	3,310	52.0%	334	52.3%	1,266	49.8%	860	62.6%	1,134	43.0%	116	39.6%
Psychosocial Case Management	9	2.8%	76	2.9%	72	5.4%	414	6.5%	76	11.9%	240	9.4%	96	7.0%	153	5.8%	9	3.1%
Transitional Case Management	14	4.3%	86	3.3%	72	5.4%	535	8.4%	20	3.1%	191	7.5%	58	4.2%	141	5.4%	96	32.8%
TOTAL	**324**	**100%**	**2,632**	**100%**	**1,327**	**100%**	**6,367**	**100%**	**639**	**100%**	**2,543**	**100%**	**1,374**	**100%**	**2,635**	**100%**	**293**	**100.0%**

Data Source: Casewatch FY 2013 (March 2013 -February 2014)

Table A.5. Retention in Care and Viral Suppression among All Ryan White Clients by Demographic Characteristics, FY 2013 (N=18,134)

Demographic	Retention in Care			Viral Load Suppression		
	Yes	Total 1*	%	Yes	Total 2*	%
Gender						
Female	1,656	2,010	82.4%	1,638	2,022	81.0%
Male	12,074	15,003	80.5%	11,793	14,797	79.7%
Transgender	227	277	81.9%	205	277	74.0%
Race/Ethnicity						
African-American	2,805	3,745	74.9%	2,604	3,720	70.0%
Asian/Pacific-Islander	531	647	82.1%	562	634	88.6%
Latino/Hispanic	7,405	8,708	85.0%	7,089	8,637	82.1%
Native American/Alaskan Native	34	50	68.0%	30	47	63.8%
Other/Unknown	12	20	60.0%	9	20	45.0%
White/Caucasian	3,170	4,120	76.9%	3,342	4,038	82.8%
Age						
0-18	30	42	71.4%	26	42	61.9%
19-24	440	664	66.3%	428	661	64.8%
25-29	1,010	1,426	70.8%	1,005	1,396	72.0%
30-39	2,967	3,812	77.8%	2,871	3,745	76.7%
40-49	4,813	5,827	82.6%	4,623	5,758	80.3%
≥50	4,697	5,519	85.1%	4,683	5,494	85.2%
Primary Insurance						
No Insurance	6,832	8,341	81.9%	6,540	8,150	80.2%
Other	62	76	81.6%	59	76	77.6%
Private	854	1,036	82.4%	925	1,033	89.5%
Public	6,196	7,791	79.5%	6,094	7,792	78.2%
Unknown	13	46	28.3%	18	45	40.0%
Income Level						
101-200% of FPL	3,389	3,969	85.4%	3,386	3,925	86.3%
201-300% of FPL	1,023	1,179	86.8%	1,043	1,163	89.7%
301-400% of FPL	377	464	81.3%	408	454	89.9%
> 400% FPL	78	103	75.7%	91	102	89.2%
≤ Federal Poverty Level	9,090	11,575	78.5%	8,708	11,452	76.0%

*Total1: Patients living with HIV and ≥1 medical visit paid by Ryan White Ambulatory Outpatient Medical Care, viral load, CD4+ T-cell, or genotyping tests during FY 2013. Total2: Patients with HIV infection and with ≥1 VL.